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Abstract

Objective: The purpose of this study was to examine the experiences of residential substance use disorder care participants with user-involvement/oriented models and processes of care, which are (1) person-centered, (2) shared decision-making, (3) recovery model, and (4) patient/person participation.

Methods: Data collection was through semi-structured, open-ended, one-on-one interviews with a convenience sample of 12 persons over the age of 18—11 males and 1 female—who self-identified as having successfully completed at least one residential program for substance use disorder(s). All interviews were recorded and transcribed, and grounded theory methodology was used to analyze the results.

Results: The experiences of the subjects in this study with residential substance use disorder care included some degree of experience with user-involvement models and processes of care. However, subjects also articulated experiences that represented the opposite of the models, and indicative of care delivery based in organizational stress and trauma, and a lack of trauma-informed care. Subjects perceived the care to be most beneficial in the presence of the models; however, good care was negated by spillage of organizational stress and trauma, and a lack of trauma-informed care.

Conclusions: The current study finds organizational stress and trauma, and a lack of trauma-informed care not only serves as an impediment to the delivery of user-involvement/oriented care models and processes in residential substance use disorder care, but it becomes the overarching phenomena that informs clinical work.

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Dr. Katherine Ledwith

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USER-INVOLVEMENT/ORIENTED MODELS OF CARE AND RESIDENTIAL
SUBSTANCE USE DISORDER CARE

Kathryn D. Arnett

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ABSTRACT

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Kathryn D. Arnett

Dr. Richard Gelles

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Epigraph

“What is addiction like for me? Living with addiction is as if my soul is a flame fighting to stay lit. At any time, with a breath, it can just blow out; I will lose the fight and cease to exist.”

Anonymous

Chapter 1: Introduction

Research Question

As a licensed clinical social worker with over 16 years of practice experience, including a subspecialty in addictions, I sought to explore best practices in substance use disorder (SUD) care. Initially, I conducted an in-depth review of the literature, which led to the development of my research. The literature suggested that best practices in SUD and other forms of clinical mental health care included four models and processes of care, which are: (1) person-centered; (2) shared decision-making (SDM); (3) recovery model; and, (4) patient/person participation. Therefore, the question guiding this research was: “What is the experience of former residential SUD care participants with user-involvement/oriented care models and processes (person-centered, SDM, recovery model, and patient/person participation)?”

The theoretical framework for understanding user-involvement/oriented care models and processes began with the work of Carl Rogers (1946). Rogers’ work transformed the field of mental health care toward a person-centered approach, evolving into the models and processes that were the focus of this study:

We regard the medical model as an extremely inappropriate model for dealing with psychological disturbances. The model that makes more sense is a growth model or a developmental model. In other words, we see people as having a potential for growth and development and that can be released under the right psychological climate. We don’t see them as sick and needing a diagnosis, a prescription and a cure; and that is a very fundamental difference with many good implications. (Rogers, 1946, p. 4)

Purpose, Aims, and Goal

The purpose of this study was to examine the experiences of residential SUD care participants with user-involvement models and processes of care. Given the length of time of residential SUD care, this modality offered the best opportunity for exploring the presence or absence of the models and processes where applicable. The aim of the research was to expand knowledge regarding SUD care best practices by increasing awareness and understanding of the experiences of former residential SUD care participants with user-involvement models and processes of care. A secondary aim was to explore the existence of parallels that may have existed among responses of former residential SUD care participants and findings of outcomes of the models and processes in the literature. Finally, the study provided a forum for former participants of residential SUD care to discuss their experiences with the care models where applicable.

The goal of the study was to provide a better understanding of the following: (1) each user-involvement model and process as it relates to residential SUD care from the perspective of residential SUD care participants; (2) the importance of concretizing the concepts for future empirical studies; and, (3) a nomenclature for the synthesis of the models and processes in order to inform future empirical studies and assist practitioners in the field with applying the concepts in a way that is congruent with the outcomes of empirical studies.

Literature Review

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) "Behavioral Health Barometer: United States Annual Report," in 2014, "In the United States, 6.6% of persons aged 12 or older (an estimated 17.3 million individuals) in 2013 were dependent on or abused alcohol within the year prior to being surveyed" (p. 13). The report

also continues: “In the United States, 2.6% of individuals aged 12 or older (an estimated 6.9 million individuals) in 2013 were dependent on or abused illicit drugs within the year prior to being surveyed” (SAMHSA, 2014, p. 14). Thus, in 2013, over 24 million individuals over the age of 12 experienced a SUD as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 (American Psychiatric Association, 2013).

That same year (2013), “In a single-day count, 1.25 million persons in the United States were enrolled in substance use treatment—an increase from 1.18 million persons in 2009” (SAMHSA, 2014, p. 16). The Center for Behavioral Health Statistics and Quality (2012) reported, “For 2012, a total of 1,749,767 substance abuse treatment admissions aged 12 and older were reported to TEDS [Treatment Episode Data Sets] by 47 states, the District of Columbia, and Puerto Rico” (p. 1). Of those admissions, approximately 297,460 or 16.7% were residential treatment stays (SAMHSA, 2012, p. 78). “Residential treatment” is defined as “short-term, 30 days or fewer of non-acute care; long-term, 30 days or more; hospital residential in a 24-hour medical care facility, excluding detoxification” (SAMHSA, 2012, p. 4).

These data reflect a high number of admissions for SUD care annually, and the cost can be substantial. Specialized SUD care centers represent a significant component of the healthcare industry and, in 2006, the gross estimated expenditure on SUD care was over \$20 billion (Kimberly & McLellan, 2006; Mark, Levit, Vandivort-Warren, Coffey, & Buck, 2007). Almost all private insurances allow one residential SUD care episode per year with a pre-determined number of stays per lifetime. However, “the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care” (SAMHSA, 2015, p.1). Therefore, access to residential SUD care will increase, especially

with the implementation of the Patient Protection and Affordable Care Act (Public Law 111-148, 2010). In keeping with the Affordable Care Act, in July 2015, Centers for Medicare and Medicaid Services provided states with guidance on ways to broaden services for SUDs, including opportunities for residential care (Department of Health and Human Services, 2015).

While access to care is a priority, and the implementation of the Affordable Care Act has made premiums more affordable for some, it is possible that even with affordable premiums, consumers may be expected to pay between 20-40% in SUD care copays (“Premiums may be low,” p. 1). However, utilization of SUD care may continue to increase despite cost, because recent federal legislation allows for equal reimbursement for SUD care (Barry, Huskamp, & Goldman, 2010) and further expanded SUD care coverage in federal healthcare reform (Buck, 2011). In 2011, it was projected the Affordable Care Act would cover 32 million uninsured Americans, 6 to 10 million of whom were believed to have a SUD and/or mental health disorder (Congressional Budget Office, 2011). As of 2014, the Office of National Drug Control Policy reported, “The Affordable Care Act includes substance use disorders as one of the ten elements of essential health benefits” (The White House, Office of National Drug Control Policy, 2014, p. 1).

Regardless of cost, these data show that effective care is worth the money spent, as SUDs result in greater expense than the services to treat it. According to the National Institute of Health (2012), “Substance abuse costs our Nation over \$600 billion annually and treatment can help reduce these costs. Drug addiction treatment has been shown to reduce associated health and social costs by far more than the cost of the treatment itself” (p. 12).

SUDs are pervasive and expensive, and accessing care can be a challenge, even with changes in legislation. Although we understand the process of recovery from SUDs may include

lapse and/or relapse, an individual's personal circumstances, insurance, access to care, time off from work, among other factors, may affect his or her opportunity to participate in or receive residential care over the course of his or her lifetime. Beyond the importance of providing ethical care, the interventions must be efficient and demonstratively effective given the access to care issues and limitations.

The Search for Successful SUD Care Outcomes

A review of current literature did not reveal a concrete definition of a successful SUD care outcome. However, in most care settings, it is agreed that an unsuccessful outcome occurs when individuals drop out of care prior to an agreed upon discharge date. According to TEDS data, "Of the 1,742,114 discharges aged 12 and older 26 percent of the discharges dropped out of treatment" (Center for Behavioral Health Statistics and Quality, 2011, p. 1). TEDS data for 2010 reports care termination in the following ways: incarceration, termination, other, dropped out, transferred, and completed. In 2010, only 44% of participants completed treatment (Center for Behavioral Health Statistics and Quality, 2011, p. 7).

Given the frequency with which persons drop out of SUD care, researchers seek to identify correlates to successful SUD care outcomes. A study conducted by Dawson et al. (2005) identified factors associated with recovery, including "female gender and being married" (p. 132). Moos and Moos (2005, 2006, 2007) identified protective factors that promoted abstinence and recovery, including self-efficacy, health status, financial status, participation in Alcoholics Anonymous, and support from family, friends, and work. Characteristics including treatment/care length, female gender, age (older adult), supportive friends, and positive life transitions predicted abstinence from alcohol and remission from five to nine years following initial treatment episode (Satre, Chi, Mertens, & Weisner, 2012). In addition, several other

studies identified characteristics that predicted low-risk drinking, including female gender, higher income, more years of education, being married, and greater social/psychological resources (Dawson et al., 2005; Ilgen, Wilbourne, Moos, & Moos, 2008; Maisto, Kirouac, & Witkiewitz, 2014).

Identifying individual characteristics and protective factors that improve care outcomes is important; however, these factors may not represent all persons engaging in SUD care. Furthermore, abstinence may not be a care outcome or goal selected by the individual receiving care. The characteristics that define recovery are unique to each individual.

Interventions, Modalities, and Outcomes

In the 1990s, the large-scale research of Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity) attempted to demonstrate successful SUD care outcomes could be achieved by matching individuals to specific types of interventions. The results of the study concluded clinicians could not match clients to treatments or interventions in order to ensure a successful outcome (Project MATCH Research Group, 1997.) In addition to the findings of Project MATCH, there is no research to support any claim that one protocol or evidence-based practice is more successful than another (Berglund, Thelander, & Jonsson, 2003). There is also variation in client responses to care, regardless of programming or interventions (Duncan, Miller, & Sparks, 2004). More recently, a meta-analysis tested whether there were significant differences in effectiveness among interventions. Findings indicated no significant differences in approaches to care for alcohol use disorders (Imel, Wampold, Miller, & Fleming, 2008).

Some studies explored whether long intervention duration resulted in improved care outcomes. Several researchers propose that longer treatment duration is predictive of successful

care outcomes (McClellan & McKay, 1998; Mertens, Weisner, & Ray, 2005; Mertens, Kline-Simon, Delucchi, Moore, & Weisner, 2012; Simpson, Joe, Rowan-Szal, & Greener, 1997).

Perhaps, the longer a person remains in a controlled environment, such as rehabilitation, the longer he/she adapts to life without use, although remaining in care for a long period may not be possible for some participants.

To complicate matters, the presence of co-existing SUDs and mental illness (MI), presents even more challenges to achieving a successful SUD care outcome. Most of the research suggests at least half of those persons with a SUD also experience MI vulnerabilities (Burnam & Watkins, 2006, p. 649). Because of the severity and chronicity of mental illnesses combined, much of the research reports the importance of an integrated approach to co-existing SUDs and MI. For example, Burnam and Watkins (2006) recommend fragmented programs and funding sources integrate care in accordance with a person-centered model of care to increase the likelihood of successful care outcomes.

Although co-existing SUDs and MI are common, and often associated with poor care outcomes, the research is limited with respect to outcomes of integrated SUD/MI care (Brunette et al., 2004). To address the challenges of integrating care, SAMHSA (2010) published a toolkit representing evidence-based practices for co-occurring disorders to assist care programs with standardizing care using best practices. In addition, practitioners can find a comprehensive listing of best evidence-based practices for SUDs on the SAMHSA website (SAMHSA, 2014). Despite the access to best practice resources, providers can develop a narrow view of what is important in SUD care: the person. Therefore, providers are cautioned “not to be so self-conscious over fidelity to a model that it dilutes any natural and effective style that engages clients in an effective working alliance” (Duncan, Miller, Wampold, & Hubble, 2010, p. 411).

Clinical Alliance and the Therapeutic Relationship

Many years of research in SUD care reinforce the importance of the alliance between client and care provider. The best predictor of outcome, even over the modality, appears to be the therapeutic relationship (Duncan et al., 2010). Ilgen et al. (2006) hypothesized the therapeutic alliance would positively affect drinking outcomes in clients treated for alcohol use disorder. The study findings indicated that clients could overcome low motivation with the support of a strong relationship between client and provider.

There is enough empirical evidence to show the importance of providers developing a strong, positive, relationship with clients, even more powerful than the modality one chooses to implement in SUD care. The early working alliance consistently predicts both client engagement and post-care substance use (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz, & Gallop, 2011; Fiorentine, Nakashima, & Anglin, 1999; Meier, Barrowclough, & Donmall, 2005). The solicitation of feedback regarding the course of care, including collaboration on care goals, improves the alliance between provider and client. Still, many times, providers develop care goals *for* clients and not *with* them, which is not consistent with person-centered care.

Person-Centered Care

Maisto et al. (2014) propose three research directions that could help improve SUD care protocols, including “real time data collection” or ongoing feedback (p. 801). The recommendation Maisto and colleagues make is congruent with research findings that illustrate feedback obtained after care has ended comes too late. Furthermore, obtaining formal feedback at each session not only promotes an early identification of a need to change modality, but also the trajectory of outcome. According to the literature, the solicitation of client feedback also

helps to develop a strong alliance between provider and client (Duncan et al., 2010). Also, recommended by Maisto and colleagues (2014) is “adaptive treatment designs,” and “more person-centered treatment options” (p. 802). Litt, Kadden, and Kabela-Cormier (2009) further discuss the personalizing of SUD interventions through the development of individually specific coping skills.

Within the literature, describing best practices for MI is the frequently cited phrase “person-centered.” Carl Rogers developed a theoretical framework for delivering therapy that placed the client at the center of care (Rogers, 1951). He believed, “Each person has the capacity and desire for personal growth and change” (GoodTherapy.org, 2014, p. 1). His philosophies were strengths-based, hopeful, person-driven, and holistic, congruent with the guiding principles of today’s recovery model care as identified by SAMHSA (2012).

A recent article published by the National Institute of Health (NIH) in the *Journal of the American Medical Association* outlines the characteristics essential to best clinical practices and includes person-centered care (Bradley & Kivlahan, 2014). Care planning with clients provides an opportunity for applying person-centered care whereby the client names his/her goal(s). The interventions are collaboratively selected and agreed upon through the process of shared decision-making (SDM), and reflect the needs and preferences of the client. McLoughlin and Geller (2010) provide a framework for care planning best practices using a person-centered approach. They discuss the pitfalls of manualized care plans, templates used by a variety of disciplines, to provide input on what each believes the client should be doing. Care plan templates may save time, but they may not reflect the client’s needs and preferences or the ways each professional discipline will support the client in meeting his/her needs. The article also speaks to the potential for incongruence between what the client wants and what the staff wants

for the client. The client will be less likely to engage in a plan he/she has not developed in accordance with his/her needs and preferences.

There is a long history of literature supporting person-centered care for SUDs and matching care approaches to individual needs and preferences instead of diagnoses (Gottheil, McLellan, & Druley, 1981; McLellanWoody, Luborsky, O'Brien, & Druley, 1983; Mee-Lee, 1995; Miller & Hester, 1986). Yet, despite the support in the literature, and grounding in Rogerian theory, the field of SUD care appears to lack person-centered approaches. Tondora (2010) discussed a number of concerns raised by providers regarding the implementation of person-centered care. Those concerns include the risk of liability in allowing clients to make their own choices and the time it would take to engage care planning based on those choices (pp. 11-13). There may be risks involved in encouraging clients to think for themselves and fostering an environment of choices and options. It is also less time consuming to offer a templated care plan and ask a client to sign it. Still, it appears to be a necessary adjustment, and a risk worth taking, to ensure the best care outcomes.

Finally, a meta-analysis exploring the impact of preferences on care outcomes concluded there is some positive effect on care outcomes when clients choose care in accordance with preferences (Swift & Callahan, 2009). However, research in this area is limited and does not reflect the degree to which choice and preferences affect care, specifically SUD care.

Shared Decision-Making (SDM)

SDM is a way of collaborating in care, sharing decisions about care and interventions, and implementing a team approach to care between provider(s) and client. A recent literature review published by Friedrichs, Spies, Härter, and Buchholz (2016) discussed the concept of SDM as it relates to SUD treatment. The article describes SDM based on its roots in medicine

and illustrates its applicability to SUD care given the success of the model in medicine. The conclusion of the comprehensive literature review included a broad scope of findings with some limitations. Only two studies the authors identified indicated that patients wanted to be involved in decisions about SUD care. The authors conclude that studies examining SDM in SUD care are limited. Yet, despite the limited presence of studies examining SDM in SUD care, the literature shows there is efficacy in the application of SDM in the context of recovery model care (Rabenschlag et al., 2014). Nonetheless, empirical data on the effectiveness of recovery approaches, which include SDM, when intervening with MI of any type are also limited (Storm & Edwards, 2012).

Joosten et al. (2008) examined the effect of SDM on the therapeutic alliance in SUD care. Findings from their implementation of a SDM intervention (SDMI) resulted in perceived favorable alliances between provider and clients. Another study by Joosten, de Jong, de Weert-van Oene, Sensky, and van der Staak (2009) examined the effect of SDM on drug use and psychiatric severity in SUD patients and produced mixed results. A SDMI resulted in positive effects on illness severity, but it had a limited effect on abstinence from substances. Again, the researchers attempted to translate the concept of SDM to SUD practice; however, these types of studies are underrepresented in the literature.

A review of the mental health literature demonstrates, while the degree of participation may vary, persons with MI vulnerabilities want to be included in decisions about their care and, likely, have had fewer opportunities to participate in decision-making than they would prefer (Curtis et al., 2010; Park et al., 2014; Woltmann & Whitley, 2010).

A statement in an article by Drake, Deegan, and Rapp (2010) summarizes the most important aspect of SDM: “Shared decision-making is an alternative to the wounding practice of medical paternalism, because it honors and values the voices of people with diagnoses” (p. 9).

The “wounding of paternalism” led to SAMHSA’s publication of “Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions” (SAMHSA, 2011). The SAMHSA publication accurately reflects the integration of recovery model care with SDM and provides a framework for intervening with clients in ways that are effective and congruent with social work practice.

Recovery Model

SAMHSA (2012) developed a working definition of recovery, which is: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (p. 3). Recovery is “the primary goal for behavioral healthcare” (SAMHSA, 2012, p. 2) and within that definition are ten guiding principles. The principles described are: “Hope, Relational, Person-Driven, Culture, Many Pathways, Addresses Trauma, Holistic, Strengths/Responsibility, Peer Support, and Respect” (SAMHSA, p. 4). These principles overlap with topics discussed earlier in this chapter, including person-centered care, and are congruent with the principles of social work practice.

SAMHSA (2013) also published “Treatment Improvement Protocol (TIP 42),” which references “The Six Guiding Principles in Treating Clients with Co-occurring Disorders (COD),” including “employing a recovery perspective” (p. 38). The specific focus on SUD care, with respect to a recovery model approach, provides a foundation for studies that have explored the utility of recovery-based interventions in SUD care.

In a recent article, Laudet and Humphreys (2013) stated, “As the SUD treatment system undergoes its most important transformation in at least 40 years, recovery research and the lived experience of recovery from addiction should be central to reform” (p. 1). The authors go on to discuss recovery in the same holistic terminology used by SAMHSA, which speaks to the core of what persons in recovery from any illness desire from life: to live a self-directed life by being the best version of themselves that they can be. Laudet and Humphreys (2013) offer an excellent summary of what occurred in SUD care and where the field is going. Historically, SUD care has not been recovery-oriented. Instead, it has been symptom-focused, using a medical model for intervention (Duncan et al., 2010; Laudet & Humphreys, 2013). Although Laudet and Humphreys (2013) discuss recovery in the context of support services as part of a comprehensive, person-centered approach to SUD care, they advocate for all care to be recovery-oriented, which began with Duncan, Miller, and colleagues (2010).

The literature also represents other recovery model proponents: those who support the patient-centeredness of recovery model approaches for all MIs, including SUDs, primarily for its comprehensiveness and view of supporting the whole person (Clossey & Mehnert, 2011; National Association of Social Workers, 2005; Tanenbaum, 2008; Webb, 2011). Clossey and Mehnert (2011) recommended assisting agencies with overcoming barriers to the implementation of recovery model care. They explored the use of appreciative inquiry, an approach that fosters growth and development of persons or organizations. The authors used this approach to help staff develop a positive attitude about helping persons with serious MI, recognizing that change must begin at the agency level.

As with patient/person-centered care, there are also those who discuss the risks of applying a recovery model approach (Davidson et al., 2006; Hardiman & Hodges, 2008,

Tondora, 2010). Some risks identified include: risk of liability, the burden on resources, and “it’s an irresponsible fad” (Davidson et al., 2006, p. 642). Despite the opposition or concerns expressed in the literature, and including those who believe in the viability of the model, yet are unfamiliar with ways to implement it, there is some validity to the challenges of the complete culture shift. Applying such revolutionary change to SUD care after decades of interventions resulting in poor care outcomes using an outdated medical model would result in a great degree of growing pains.

In addition to recommendations for change in agencies that provide services to persons experiencing MI vulnerabilities, some researchers identified a need for recovery model education within disciplines such as psychology and medicine (Mabe, Ahmed, Duncan, Fenley, & Buckley, 2014). Mabe et al. (2014) engaged an ambitious effort to transform a university’s department of psychiatry into a completely recovery-oriented learning environment. It was the researchers’ belief that change begins in the educational institutions. The research endeavor resulted in several successes, including the inclusion of clients on advisory councils, in accordance with the concept of patient/person participation. In addition, the project made recovery-oriented principles routine in the education curriculum, thereby ensuring it is more common practice than phenomena. Within the project, the authors recommended, for future directions, empirical studies to explore the degree to which academic settings promote recovery-oriented care.

Patient/Person Participation

In a broad context, patient/person participation includes involving patients/clients in agency decisions, hosting forums, community meetings, and other opportunities for clients to provide input and share in the vision, development, and quality improvement of the agency. It gives clients a voice, facilitates ownership and responsibility (congruent with the characteristics

of recovery model), and offers clients an opportunity to be critical change-agents in the agency's improvement process.

In the context of service delivery, patient/person participation advocates for more than simply explaining services and seeking a person's consent for care. First, consent for care goes beyond signing a consent form and includes SDM wherein providers and clients explore options together. Often in mental health care, the professional is in charge and makes all care recommendations with clients having minimal say throughout the care continuum. It is a paternalistic, "I know what is best for you," approach to intervention that becomes more paternalistic with severity of illness.

As early as 1979, Bordin reported agreement between provider and client on care goals was one of the core components of a therapeutic alliance. Zhang et al. (2008) showed improved care outcomes with agreement and adherence to care plans. Yet, the study uses the words "agreed/adhered" as interchangeable terms. In some instances, clients may not agree to care plans but will adhere, especially if motivated by consequences or certain circumstances such as legal mandates. Nevertheless, it appears in the literature that considering the goals, needs, and preferences of the client positively affects outcome.

Rapp et al. (1993) discussed a strengths-based approach to SUD care that outlined the importance of clients setting their own goals and the provider/care coordinator acting as a consultant in the client's care. While the authors discussed the approach in the context of care management and coordination, the concepts are congruent with recovery model care and overlap with patient/person participation and SDM.

Also within the literature evaluating SUD care outcomes, many researchers cite abstinence as the most important goal (Duncan et al., 2010). Not all persons who seek SUD care

desire or are ready for abstinence. When programs accept that the client may be more interested in reducing high-risk use or addressing underlying issues, they are in a greater position to affect and promote change (DiClemente, Nidecker, & Bellack, 2008). Regardless of what outcome a client seeks, allowing and encouraging the client to name his/her goals and choose interventions that support achievement of those goals, is the operationalization of a person-centered approach to care that includes the patient/person in the process of SDM.

User-Involvement/Oriented Care Models and Processes (Person-Centered; Shared Decision-Making; Recovery Model; Patient/Person Participation)—A Synthesis

Although the research is limited, user-involvement models of care and processes appear to have a positive impact on SUD care outcomes when applied with some demonstration of overlap. Absent in the literature are empirical studies examining the impact of a synthesis of the models on SUD care outcomes. Scott D. Miller (Duncan et al., 2010) and colleagues have been most successful in identifying the importance of synthesizing user-involvement models and processes of care in SUD intervention, although they do not define the principles specifically as “user-involvement care models.” The meta-analyses conducted by Miller and his colleagues reference the concepts, individually stressing the importance of their comprehensive inclusion as best practices in SUD care, treatment, and services (Duncan et al., 2010).

Miller and his colleagues propose advances in SUD care, which they believe would significantly improve care outcomes. Recommendations include person-centered care plans, early and frequent opportunities to obtain feedback from clients regarding their perception of care (person/patient participation), alliance between provider and clinician, and use of client feedback to shape ongoing care (Duncan et al., 2010). The authors consider the care plan a collaborative and living document, including shared decisions about how to proceed with care.

In their book, Heart and Soul of Change, Duncan et al. (2010), discuss their concerns about a common practice in SUD care, which is the treatment/care “track” (Duncan et al., 2010, p. 406). Tracking care based on pathology is in opposition with patient/person participation, where the client makes informed decisions about his/her care based on needs and preferences. Tracking by pathology results in the practitioner deciding when the client moves forward in accordance with compliance with care and the provider’s determination of progress. Also incongruent with recovery model care, this approach focuses on pathology or illness and not strengths and abilities. Duncan et al. advocate for ensuring the client, with the support and consultation of the provider, guides his/her care and outcome trajectory. Recovery-oriented care requires a shift in service delivery, a requirement for staff to be flexible and open to the desires of clients, and assist with the development of collaborative, person-centered care plans, which include the stated goals of the individuals served. All of the concepts discussed by Duncan et al. (2010) represent a synthesis of user-involvement models and processes of care.

An article published by Storm and Edwards (2013) appears to be the first publication to advocate for the implementation of user-involvement care models and processes (person-centered; SDM; recovery model; and, patient/person participation) in a synthesized manner. Duncan et al. (2010) discussed the concepts without the use of overarching terminology, and Storm and Edwards (2013) developed a nomenclature synthesizing the concepts as “user-involvement models” (Storm & Edwards, 2013, p. 313).

The use of nomenclature is critical for the development of further studies, especially given the overlap and common features of the concepts and the potential for describing one without mention of the others. For example, a person-centered approach encourages the individual’s participation (person/patient participation) in the form of voice and representation.

It also includes opportunities for SDM as a forum for implementation of the approaches.

Ensuring care participants lead their care encourages the development of goals that will move them toward a life of his/her choosing; hence, recovery model.

Storm and Edwards (2013) use the term “user-involvement” as an overarching phrase emphasizing the importance of a balanced approach to implementation of the models in a mental health care setting. From a psychiatric nursing perspective, the authors advocate for the application of all of the models and discuss the challenges for implementing them in an inpatient mental health setting. Although the article does not speak specifically to SUD care and further explores the concepts individually using overarching terminology, the article represents an important effort toward creating a framework for models and processes of care that would likely maximize outcomes when applied in a synthesized manner. The question becomes, if the literature demonstrates improved care outcomes with the application of each model applied separately, would a synthesized approach lead to greater improvement in care outcomes.

A review of the SUD intervention literature reflects advocacy for each user-involvement care model and process and effective outcomes of care with the implementation of each; however, the SUD literature does not include empirical studies that discuss care outcomes in settings using all, or the effectiveness of the models and processes implemented in a synthesized manner. Finnell and Lee (2011) endorse a person-centered approach to SUD care and the inclusion of clients in the development of care plans. They include SDM as important for a person-centered approach where clients have choices from several options of care. In their study, the researchers attempted to establish a psychometric measure to assess client decision-making. While the study’s aim was toward person-centered care, there appeared to be several limitations. It seems the authors were attempting to develop a tool for weighing the pros and

cons of care options. Perhaps a tool is not as effective as having a conversation about options through the process of establishing rapport or client-provider alliance. It may be more prudent to explore the outcome of providing clients with a range of choices of interventions. In other words, applying a holistic approach to care, offering a variety of interventions from support services to evidence-based care, and then evaluating the impact of such choices on care outcomes, may provide more information about SUD care outcomes in general.

In a study conducted at the University of New South Wales (Brenner et al., 2009), the researchers report that drug treatment participants had positive outcomes when participating in their care. This is an important study for identifying positive outcomes based on the overlap of patient/person participation and SDM. The researchers use the overarching term “consumer participation,” which, as described in the study, encompasses positive outcomes experienced with the client’s opportunity to be included in care planning; thus, SDM. In addition, the terminology describes the concept of patient/person participation whereby clients have knowledge of their rights. Although the terminology differs from studies conducted in the United States, it is important to focus on the positive outcome of care driven by these concepts as described by the study.

Evaluating whether SUD care participants want to make choices regarding care may be premature with a population historically made to believe they are too sick to make their own choices. Again, it may be more advantageous to offer choices, support clients as they explore their options, and evaluate outcomes based on a synthesis of user-involvement models and processes of care. Nevertheless, offering care and intervention choices is person-centered, and applies an individualized approach to care planning.

SUDs affect the lives of millions of persons every day as indicated by the statistics reported in this dissertation. Changes in healthcare legislation point to the likelihood more persons will seek help, and, ideally, those persons could expect the most advanced and comprehensive care possible. The exploration of the current literature revealed the importance of applying user-involvement models and processes of care (person-centered; SDM; recovery model; and, patient/person participation) in SUD care, treatment, and services. Nonetheless, current studies that examine the user-involvement models of care in SUD treatment are limited and, furthermore, represent a great degree of overlap without identifying care outcomes that are specific to each model or process. There appears to be no empirical study that examines SUD care outcomes based on a synthesis of the four models and processes.

On the surface, simply applying the approaches in a synthesized manner might be a step in the right direction. Yet, with the mere diagnosis of SUD, care participants have faced discrimination with respect to the clinical course of the illness, and the field is only recently beginning to recognize the importance of removing the barrier of stigma for persons seeking help (Committee on the Science of Changing Behavioral Health Social Norms, 2016). Consistently held accountable for aspects of their illness, persons with SUDs have had limited control over the course of their care, resulting in a paternalistic approach to care that includes shame and blame. The result is varying degrees of client input in their own care and limited empirical studies of outcomes based on a synthesis of user-involvement models and processes of care.

The limited empirical research of residential SUD care outcomes following the implementation of user-involvement/oriented models of care provided the basis of this qualitative study. The guiding research question was “What is the experience of former residential SUD care participants with user-involvement/oriented care models and processes,

which are (1) person-centered care; (2) shared decision-making; (3) recovery model care; and, (4) patient/person participation.”

The aim of the research was to expand knowledge regarding SUD care best practices by increasing awareness and understanding of the experiences of former residential SUD care participants with user-involvement models and processes of care. A secondary aim was to explore the existence of parallels that may have existed among responses of former residential SUD care participants and findings of outcomes of the models and processes in the literature. Finally, the study provided a forum for former participants of residential SUD care to discuss their experiences with the care models where applicable.

The goal of the study was to provide a better understanding of the following: (1) each user-involvement model and process as it relates to residential SUD care from the perspective of residential SUD care participants; (2) the importance of concretizing the concepts for future empirical studies; and (3) a nomenclature for the synthesis of the models and processes to inform future empirical studies and assist practitioners with applying the concepts in a way that is congruent with the outcomes of empirical studies.

Chapter 2: Methods

Literature Review Methodology

This qualitative study began with a comprehensive review of SUD care literature using EBSCO host (University of Pennsylvania), Google Scholar, and PubMed, which resulted in a review of approximately 230 articles, narrowed to those included in this dissertation. The aim of the review was to explore the research of user-involvement models and processes in SUD care, treatment, and services. Although I reviewed all related literature, including studies that explored the models in other areas of mental health care, I maintained a specific interest in exploring the presence of the models in residential SUD care. I concluded a residential SUD care length of stay might offer the best opportunity for studying the presence of the models and processes by virtue of increased opportunities for implementation and evaluation. Nevertheless, I considered all studies based on their relevance to the application of user-involvement models and processes of care and SUDs, regardless of SUD type, level of care, or the characteristics considered as successful care outcomes by the researchers (Arnett, 2016).

Qualitative Research Design

I chose a qualitative study to explore a topic about which little is known. Given that there are no empirical studies that present outcomes of residential SUD care based on the implementation of a synthesis of the models and processes, it appeared prudent to begin the study by hearing and learning about the experiences of care participants. Furthermore, although the experience of residential care is unique for each individual, I explored the possibility care participants experienced an overlap of the models and processes, or at least had an experience with one or more, and I wanted to learn about the ways the models and processes impact the outcome of each person's care from their perspective.

For this study, I carefully considered the best approach to exploring my research question and employed the grounded theory method (Glaser & Strauss, 1967). Because I planned to interview subjects to examine their experiences with residential SUD care, I read the text, *Constructing Grounded Theory* (Charmaz, 2014). I developed an appreciation for Charmaz' systematic and practical approach to data collection, and believed, if I followed this strategy, a theory would emerge from the data. Charmaz writes that the process of constructing grounded theory begins with a "research question, and proceeds through the identification of participants in the study, data collection, initial coding, focused coding and categorizing, theory building, and writing" (Charmaz, p. 18). The steps presented by Charmaz provided a foundation for the systematic approach I sought for examining the lived experiences of subjects with respect to residential care and included a thorough description of ways to gather, analyze, and report the data. Charmaz also explained that memo writing would provide a foundation to data analysis and would, therefore, help me connect fragmented data for the emergence of theory.

Questionnaire Development, Changes, and Adjustments

After reading and learning about the qualitative approach of grounded theory method, I developed an open-ended questionnaire to examine subjects' experiences in residential SUD care with person-centered care, recovery model, SDM, and patient/person participation. Initially, there were approximately 20 questions (excluding probes and wrap-up questions) that specifically explored experiences with the models. Questions included model and process overlap similar to findings in the literature. I ensured that the subjects had opportunities to expand on their experiences, as needed, of any of the topics examined (Appendix A).

After the first two interviews, I added additional probes, as subjects' responses were much more thoughtful with deeper probes. In addition, I began to feel more comfortable with

the process to explore the content more deeply. The same questionnaire was used for the first four interviews; however, additional questions were added for the remaining interviews. When the first four interviews were fragmented, coded, and in the development of focused codes, a pattern of responses emerged. The additional questions were added to illuminate the pattern of experiences presented by the first four interviewees. Further outcomes are discussed later in this dissertation.

Sampling

Because I planned to conduct in-depth interviews, I recruited a purposive sample of subjects based upon the inclusion and exclusion criteria (Appendix A).

Subject recruitment strategies. I developed two spreadsheets to record recruitment efforts, which began with the first Institutional Review Board (IRB) approval dated 19 February 2016 (Appendix B). The first spreadsheet identifies the 28 locations where I placed flyers to advertise the study beginning 28 February 2016 (Appendices C and D). The locations consisted of churches and other organizations in the Bethesda and Gaithersburg, Maryland, areas, which hosted 12-Step and other types of self-help meetings I identified by Google search.

The second spreadsheet represents data from emails and phone calls to 40 contacts from 3 March to 19 April 2016 (Appendix E). Of those contacts, two agencies refused to advertise the study citing no particular reason other than, “We don’t want to participate.” I explained the study during all correspondence and included a cover letter discussing the purpose of the study and desire for advertising without the agency’s participation in the study. Nonetheless, two agencies declined.

I used social media (Facebook) to inform friends and colleagues of the search for subjects and asked that persons with questions email or message me directly to avoid the public exposure

of self-identified subjects. The posting resulted in several of the contacts included in the email/telephone spreadsheet. At the end of the study, I interviewed 12 subjects: one was identified through the flyer advertisement, and the remaining 11 came through colleague referrals.

Despite the multiple efforts at enlisting subjects, I found that this was the most difficult aspect of the research. It is likely that discussing a time in one's life that is a reminder of shame or trauma, is much more difficult for people than I anticipated. After all of the advertising in community agencies that agreed to advertise my study, and places that host community meetings, I received very few calls. The majority of my subjects were referred by colleagues. It appears that stigma for SUD remains in spite of the gains that we have made in the field of practice. This is also indicated by the Committee on the Science of Changing Behavioral Health Social Norms (2016).

Research Setting

The research took place in public places with opportunities for private discussion, such as libraries, bookstores, and coffee shops. I also met subjects in a halfway house for men, many of whom reported they had participated in two or more residential SUD care programs.

Sample Size

The total number of subjects for this study was 12. The data collection ceased when responses were similar and the data were saturated (Padgett, 1998) with information on the four models and processes I was examining, and in the presence of an emerging theory.

Subject Demographics

I created a spreadsheet to capture the demographic data of the subjects (Appendix F). Of the 12 subjects, 11 were men. Other than the one woman who participated, no women inquired

about the study. The age range for the subjects was mid-20s to mid-60s. Age did not appear to be a predictor of the number of residential care episodes. Some of the subjects had been through at least two residential stays and some as many as 10. From a socioeconomic standpoint, every subject reported difficulty maintaining employment due to use of substances. All subjects reported financial struggles that resulted from use, and residential care was an opportunity for them to gain the stability they needed to reengage the work force.

Four of the subjects reported their race as “Caucasian,” seven reported their race as “Black or African American,” and one reported “Mixed Colombian and Black.” All subjects reported co-existing illnesses including schizophrenia, mood disorders, anxiety disorder, and personality disorder. Three of the subjects reported difficulty resulting from use of only one substance: alcohol or heroin. The remaining nine subjects reported difficulty resulting from use of more than one substance at any given time. Three subjects participated in short-term residential care (30 days or fewer), and the remaining nine participated in long-term care (30 days or more). All subjects reported at least one care episode or stay resulted in what they perceived as a successful completion. Nine subjects’ care was voluntary, and one was mandated. Ten of the subjects reported relapse after participating in their most recent residential care episode. Most of the subjects did not attribute relapse to the quality of care they received. Instead, they attributed relapse to not having followed a continuing care plan.

Interview Process

I recorded interviews using an audio recorder, and each interview was transcribed verbatim. The interviews ranged from approximately 40 to 120 minutes in length. Prior to beginning each interview, I reviewed the Penn Consent Form (Appendix G) with each subject, obtained the subject’s signature, and offered each a signed copy. Only two subjects expressed

interest in a copy of the consent form. I gathered demographic data on the face-sheet, and proceeded with recording the interviews. My questions were written on index cards to allow me to focus on responses without losing my place with the questions. I did not take notes beyond the data gathered on the face-sheet. Following the interview, subjects were paid \$10.00, as agreed and indicated by the Penn Consent Form.

Subject Data Inventory

I maintained an accurate and complete inventory of all interview data, which included: (1) consent form: (2) face-sheet data: (3) interview transcript: (4) notes: (5) open codes: (6) focused codes; and, (7) memos.

Institutional Review Board and Changes to Inclusion Criteria

As mentioned above, my research was approved by the Institutional Review Board (IRB) on 19 February 2016. In that submission, I requested approval to interview subjects who participated in residential care within the last two years (2014 and 2015). The first subject's reported episode of care did not fall into that category; however, I chose to conduct the interview when he reported having participated in a care at a facility that provides care to wealthy clients. I was interested in hearing about his experience in a facility with considerable resources and wondered how his responses would compare to those of persons who participated in state-funded programs.

Although the first subject's care experience was 10 years ago, he still seemed to be working through the stigma of having participated in care and of the circumstances that led to care as indicated by responses during the interview. I wondered if, perhaps, the time elapsed since treatment would make it easier for some people to share their experiences given the stigma of SUD care (Committee on the Science of Changing Behavioral Health Social Norms, 2016).

Therefore, based on my interest in learning about experiences from a variety of care settings, and given that the topic is of a sensitive nature, potentially making it more difficult for subjects to share very recent experiences, I expanded my inclusion criteria to include any residential care episode, during any period of time, with the caveat that we would discuss the most recent care episode. I resubmitted my proposal to the IRB, and it was approved for 25 March 16. The second subject I interviewed completed care in 2014. Therefore, I proceeded with the interview before the second approval from IRB. The remaining subjects participated in care between 2005 and 2016. By 7 May 16, I coded and analyzed the first four interviews and I began to see the emergence of a patterns that led toward theory building.

Data Collection

My data collection method was in-depth, open-ended, one-on-one, semi-structured interviews to explore the experiences of former residential SUD care participants. I developed an interview guide that I adjusted as needed to include additional probes and additional questions following the first four interviews. It was necessary to re-word, re-order, and clarify questions to ensure that the topics of inquiry were fully investigated. The interview guide ensured consistency with addressing topics during interviews; however, the interviews were conversational, thoughtful, and subjects were encouraged to elaborate whenever it was indicated.

The process of data collection included the following steps: (1) recorded interviews lasting 40 to 120 minutes; (2) complete, verbatim transcription; (3) review and reading of transcribed data; (4) fracturing data beginning with line-by-line, in-vivo, and preliminary codes; (5) writing memos as I reviewed provisional codes, discovering similarities or differences between interviews, relationships between concepts and theory; (6) further fracturing the data and grouping similar codes together; (7) developing provisional categories and themes related to

the four models and processes of care that provided the basis for open-ended questions; (8) axial/next step coding and the development of relationships and dimensions of categories; and (9) the emergence of theory based upon final coding.

Memos

Following the transcription of each interview, I wrote memos on the transcript and on separate word documents that I later flushed out extensively. In a free-flowing manner, I annotated my questions, concerns, observations, areas I wanted to explore further, and everything that came to mind that would help me analyze the data. I found that later, the memos became the foundation for theory building. In analyzing transcripts, I was beginning the process of analyzing my coded data, which helped me to tie together my processes.

Reflexivity

As the research instrument, I maintained a journal to capture ongoing thoughts and feelings experienced during the study. As each interview concluded, I recorded the process of recruitment, questions, concepts for further study, and random thoughts and concerns. I utilized the process of reflexivity to address biases, attitudes, and values that affected how the data were gathered, analyzed, and interpreted.

In addition, I maintained contextual data on each interview to inform the process of reflexivity that included the following: (1) date/time of interview for the purpose of evaluating correlates to quality as indicated; (2) taping/recording concerns; (3) observations made about the subject; (4) non-verbal behavior and/or smells; (5) distractions/sounds heard; (6) demeanor of subject; (7) my responses throughout including active listening; (8) my overall reaction to the interview; (9) where the data were analyzed; and, (10) process of analysis.

Journaling and recording observations helped me process my thoughts more thoroughly. I found that I could connect with the subjects in the same way that memos and coding helped me to connect to the data. When I fragmented the data, the phrasing, as it stood alone, became very powerful, especially as patterns emerged. The journaling provided me with a context for coded data and a space for recording my reactions to individual subjects and the content of their discussions, which helped me as I approached the next interview. Working through my thoughts and feelings allowed me to engage the next interview with more objectivity.

I was also able to see how my clinical practice experience had the potential to both facilitate and hinder the process of data analysis. Were it not for my clinical practice experience and advanced clinical studies, I would not have been able to identify the theory that emerged from the data. On the other hand, my practice experience led to my bias and belief that subjects would likely report limited if any, experience with the models and processes. In my own experience with organizations I have served, SUD care is substandard; yet, I realize this is a rather limiting perspective. Even within organizations where care is substandard, it is possible that the models and processes are represented in some fashion, as was the result of this study.

Journaling also helped me with countertransference. During certain interviews, I was reminded of clients I served in the past and journaling helped me to engage the data more objectively. I was further reminded of my own past experiences with vicarious trauma, caring for clients who lost their lives as they desperately tried to engage recovery. Overall I felt grateful that I have significant clinical experience and knowledge of vicarious trauma, as this helped me to gather and analyze these data, while remaining intimately connected to the process.

Chapter 3: Results

The purpose of this study was to examine the experiences of residential SUD care participants with user-involvement/oriented models and processes of care. Given the length of time, and the potential for interface between clients and providers, residential SUD care offers a significant opportunity for exploring the presence or absence of the models and processes where applicable. The aim of the research was to expand knowledge regarding SUD care best practices by increasing awareness and understanding of the experiences of former residential SUD care participants with user-involvement models and processes of care. A secondary aim was to explore the existence of parallels that may exist among responses of former residential SUD care participants and findings of outcomes of the models and processes in the literature. Finally, the study provided a forum for former participants of residential SUD care to discuss their experiences with the care models where applicable.

The goal of the study was to provide a better understanding of the following: (1) each user-involvement model and process as it relates to residential SUD care from the perspective of residential SUD care participants; (2) the importance of concretizing the concepts for future empirical studies; and (3) a nomenclature for the synthesis of the models and processes in order to inform future empirical studies and assist practitioners in the field with applying the concepts in a way that is congruent with the outcomes of empirical studies.

Data Analysis

I used an inductive approach to analyze the interview transcripts, identifying patterns in the data by means of thematic codes, in order to generate theory. “Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis” (Patton, 1980, p. 306). I

employed grounded theory method, which, “is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon” (Strauss & Corbin, 1990, p. 23).

In coding using in-vivo, open codes, I fragmented the data into focused codes and further fragmented and analyzed thematic codes and concepts. I identified patterns that facilitated the emergence of theory. Initially, I coded the data according to the presence of experiences with the four models and processes of: (1) recovery model; (2) person-centered care; (3) SDM; and, (4) patient/person participation. For each interview, I transcribed, coded and focused coded the data, and created lists of the focused codes, categorizing responses by the four models.

The following are examples in subject’s words of how the data represented the models and processes:

Recovery Model (Appendix H) – “They [staff] focused on my strengths, the care was holistic, they [staff] expect everyone to complete successfully, walk out and stay sober.”

Person-Centered Care (Appendix I) – “Asking if my needs were met, respected where I was, talked about stuff not related to drinking.”

Shared Decision-Making (Appendix J) – “I was heavily involved in the care planning, I wanted to be involved and voice my opinions, my counselor offered professional suggestions.”

Patient/Person Participation (Appendix K) – “At the end there was always a questionnaire to fill out, we were asked to form a board with a president and secretary.”

After continuously fragmenting and coding the data, I found that the first four lists of coded data were themes that clearly demonstrated a presence, although inconsistent, of the four models and processes in the subjects' most recent experiences with residential SUD care. The most predominant presence was recovery model, then person-centered care, and then SDM, with the least represented being person/patient participation.

Person/patient participation is more than the opportunity for a care participant to provide consent for care. It affords an opportunity for care participants to be a part of program development through feedback, forums, and other opportunities. As discussed earlier in this dissertation, person/patient participation is somewhat new, and likely the reason it was the least represented in the data for the current study. The first four lists representing the presence of the four models and processes did not account for all data. Therefore, when the lists were completed, I continued coding until I identified additional themes.

Readiness for Change

The next list of themes I identified after coding the data related to subjects' report of readiness for change (Appendix L). The first question I asked every subject was, "When you entered the program, how ready were you to make changes?" Responses included, "I was absolutely prepared to make changes," "I was beaten down," and "I was ready, I was at a point where I needed help." These responses left me to wonder whether persons who perceived themselves as very ready to make changes would have successful care outcomes. I found that all subjects perceived their care outcomes as "successful" for having completed the treatment, regardless of their stage of change at care onset, and whether they believed any change came from having participated in care.

Consequences of Use

The next group of themes to emerge from the coded data that was not better accounted for by the four models and processes was related to consequences of use. While each subject reported some degree of readiness for change, the themes in the data indicated the subjects' discussion of readiness was in relation to the consequences each reported experiencing as a result of chronic use (Appendix M). In their own words, subjects reported consequences like, "I had several hospitalizations," "I lost jobs," "I damaged my family relationships," and "I could not stop on my own." Each subject articulated the degree of devastation he/she experienced from continued use and the ways his/her use had a negative impact on values, quality of life, and family relationships.

Negative Outcomes and Contributing Factors

The data represented additional themes and patterns beyond those themes and categories identified above. All subjects, with the exception of two, reported relapse at some point after treatment. One subject reported being sober (or abstinent) from substances for 10 years, which was his goal for care. The other shared her experience of the most recent episode of care after approximately nine rehabilitation episodes of care. She reported she did not know why she was able to continue abstaining from alcohol following her last care episode.

For those who relapsed, I identified and consolidated the themes for negative outcomes and contributing factors (Appendix N). The consolidation included themes in subject's own words including, "I use when things are going well," "It's a disease," and "I recently lost my mom." At least two subjects reported relapse over the loss of a loved one or experiences with emotionally and physically abusive relationships. This led me to wonder if these subjects learned any new coping skills. Some subjects reported relapse was based on issues they were

unable to address in care and feeling “let down” by the care they received. This led to my further in-depth exploration of themes and patterns of codes on the specificity of the care received.

Positive Outcomes and Contributing Factors

As I considered the negative outcomes and how some of the themes of contributing factors were directly related to the care subjects received, I explored the themes of positive outcomes and those contributing factors (Appendix O). I discovered that some of the subject’s reported positive outcomes and contributing factors appeared related to the care experience, just as some of the negative outcomes were. Subjects reported themes like “They [staff] gave me confidence,” “They [staff] believed in me,” “Staff believed I would come out and have a successful recovery,” “They [staff] gave me hope and confidence,” and “They [staff] gave me psychological tools.”

I strongly considered the variation in themes between the presence and absence of positive outcomes and how some of these experiences were specifically related to the care itself. I started to think about the remaining themes and began to notice that some of the remaining data represented the *absence* of the four models and processes. Within the remaining data, there were themes that represented the presence of the four models, and themes that represented an absence of the models. Simply stated, sometimes the models were practiced, and sometimes, the care delivered was the complete opposite of the models. For example, subjects reported the following with respect to the four models and processes:

Absence of Recovery Model (Appendix P) – “Staff were iffy about my recovery, you can’t be dirty there’s no tolerance for use, sometimes staff just didn’t want to interact with certain people.”

Absence of Person-Centered Care (Appendix Q) – “We were given a care plan, everyone goes to the same class every day and it’s mandatory, you’re expected to go or they discharge you.”

Absence of Shared Decision-Making (Appendix R) – “You’re not the captain of the ship, your opinion might not be the best right now, I did what I was told during treatment.”

Absence of Patient/Person Participation (Appendix S) – “I don’t know if my feedback was ever incorporated, I would have liked them to read the suggestions in the suggestion box.”

The Emergence of Theory

Within these data, themes emerged reflecting both the presence and the absence of all four models and processes (recovery model, person-centered care, SDM, and patient/person participation). The data indicated that subjects in the study experienced a great degree of variation in the delivery of the models. When all the data were coded, there remained a group of codes, larger than any other group, and not represented by any categories. As I further analyzed the codes, I found that they were best represented by a manifestation of organizational stress and trauma and the absence or lack of trauma-informed care.

As I carried out the study, I expected to find that at least one or more of the four models and processes were not practiced at all. Even in the experiences articulated where the facility and programming were less than desirable, subjects reported some staff intervened in a way that represented some application of the models and processes. Therefore, a synthesis of the four models and processes were experienced by subjects in the study to some degree. However, when subjects discussed the absence of the models, or described experiences in which the models were not practiced, there appeared to be an additional theme emerging in the data. As I continued

fragmenting, coding, and identifying themes, I identified patterns reflective of organizational stress and trauma and a lack of trauma-informed care.

Organizational Stress and Trauma and a Lack of Trauma-Informed Care

Organizational stress and trauma, and a lack of trauma-informed care appeared to impede the delivery of user-involvement/oriented models and processes, according to the subjects in the study. For example, subjects reported the following, which were consolidated into a list of themes (Appendix T):

- “I was lucky to have a skilled counselor.”
- “Some counselors come down hard on people.”
- “They [staff] had the opinion addicts deserve what they get.”
- “Very punishing point of view.”
- “Felt condescending.”
- “They thought I was there to pull the wool over their eyes.”
- “A lot of addictions counselors are jaded.”
- “There were lots of statistics, they said some of us weren’t going to make it.”
- “They [staff] said I hope she frickin gets it this time.”
- “Unprofessional.”
- “Staff are pessimistic because of what they see.”
- “When someone completes treatment, staff are pleasantly surprised.”

As mentioned, the list of codes representing organizational stress and trauma, and a lack of trauma-informed care, was the longest list of codes resulting from data collected in this study. This list of codes was longer than the list for the presence or absence of any one user-involvement model or process. This list was also longer than the lists for consequences of use,

readiness for change, positive or negative outcomes. Finally, this list captured the largest representation of thematic findings.

Theory. The theory that emerges from the data in this study is that organizational stress and trauma, and a lack of trauma-informed care (including vicarious trauma, and burnout), impedes the delivery of user-involvement/oriented models of care, which includes recovery model, person-centered care, shared decision-making, and patient/person participation. Furthermore, when the impediments exist, not only is the delivery of the four models and processes negated, but, the subjects of this study appeared to be re-traumatized and re-victimized as a direct result of what appeared to be staff's own unresolved traumatization.

Chapter 4: Discussion

Presence of the Four Models and Processes

The most striking aspects of the results of this study are the similarities in experiences articulated by the subjects. Each subject shared devastating consequences of substance use prior to the onset of care. Subjects' accounts of experiences included difficulty maintaining employment, housing, and compromised relationships with loved ones. Subjects shared that loved ones either terminated relationships or threatened to terminate relationships if subjects did not agree to treatment. This is important for understanding the degree in which our clients are vulnerable and often feel alone, and therefore what we expose them to is profoundly important.

Not all subjects reported feeling ready for change. Each discussed his or her own point of desperation that led to the decision to seek help. Subjects reported feeling open and willing to engage the care, forming a relationship with providers with some degree of trust. The willingness to engage in care illustrates the importance of recognizing that clients come to us in very different stages of change. How well are we meeting their needs when we have not provided care that is congruent to the stages of change in which they present? Regardless of change stage, each subject in the current study entered care hoping to be treated with dignity and respect.

Of the four models and processes, the most represented by subjects' experiences was recovery model care. Subjects discussed the value and importance of the relationships they shared with their counselors, whether they respected their counselors and felt respected or whether the counselors focused on their strengths and supported them. Subjects discussed the ways a sense of community develops and is cultivated in residential SUD care, where clients support one another as they learn to trust and make connections with others. This community

support also helped them to better manage the organizational stress they encountered from staff. In hearing about the importance of community, I understood subjects' experiences in the context of the isolation they reported feeling upon entering care and treatment, each having discussed devastating consequences. It seemed that the recovery model provided a foundation for the subjects to begin feeling like a part of something again, in the presence of persons, mostly peers who supported and celebrated their efforts at help-seeking. In interviewing the subjects, I often heard them talk about the biopsychosocial impact of use of substances, and how important it was for them to find care that was holistic in addressing their physical, emotional, social, and spiritual needs, as is indicative of recovery model care.

Subjects discussed experiences with person-centered care where they were asked by staff about their needs and preferences, and yet, in many cases their experiences suggested that this effort was negated by "one size fits all" care plans. In programs where the resources were available and adequate, subjects reported experiences indicative of a greater focus on person-centered care, including care for co-existing illnesses. It seemed that asking someone about his or her needs and preferences is futile if the resources do not exist to individualize care. Subjects in the current study shared the very personal results of their use of substances, and how they wished the care had been more individualized and culturally-based.

Shared decision-making, the process of discussion and collaboration between client and provider(s) appeared to overlap with person-centered care in the results of the study. Some subjects reported they were asked about needs and preferences, which was a person-centered approach, and they shared in some of the decisions based on their needs and preferences. However, decisions were mostly shared when subjects reported informing their providers that the they needed a change or an adaptation to care. Those subjects reporting the most experience

with shared decision-making also reported attending a rehabilitation program with the resources to offer a variety of care options. Perhaps the more care options available, the more likely staff offer the opportunity to collaborate on decisions.

Very few subjects reported experiencing person/patient participation. All subjects recalled signing a consent form for care upon program entry. At least four subjects recalled completing feedback questionnaires; however, they were not sure of the outcomes. Only one subject recalled participating in a program where clients were included in program improvement initiatives, such as forums or other client panels.

Absence/Opposite of the Four Models and Processes

Examples of the opposite of the four models and processes were evident by the subjects' responses. As I read through the themes and codes, I was struck by how sad it made me, that all of the negative experiences subjects disclosed had occurred in a care setting. I thought about how victimized and re-victimized subjects must have felt in these experiences. Coding the data, I immediately recognized the themes that clearly represented the opposite of the models and processes.

As subjects discussed the absence of the recovery model, the most pervasive theme was the ways staff informed clients that they would die if they continued using. Staff quoted statistics about use, using scare tactics that some subjects reported made them feel angry. One subject shared, "I'm not a statistic, and I'm going to beat this!" As professionals in a subspecialty, it is easy to become jaded; however, we know that scaring people into engaging care is not only ineffective, it is unethical. As subjects shared these experiences, it was evident they were negatively impacted and any care delivered in a quality manner may have been negated by the scare tactics alone.

For some subjects, the care was not person-centered, nor did it include shared decision-making. Some subjects reported being given a standardized/template care plan that was not reflective of needs and preferences, although they were asked about needs and preferences. Some subjects shared that the care was delivered “one size fits all,” and often times, the subjects felt pushed through without what they perceived as adequate time spent on specific issues. In some cases, subjects found the care to be overly focused on superficial issues like “triggers for use,” as opposed to use as a coping mechanism for underlying issues and/or co-existing illness. When certain staff members took time out to address specific needs, subjects reported this type of initiative made them feel valued.

It is important to note there was some variation in the degree in which subjects wanted to be included in decisions, which is consistent with the literature on shared decision-making. Some were adamant about being included, others felt defeated and helpless, believing they were incapable of making decisions about care. Some subjects reported being reminded repeatedly by staff that they were indeed incapable, or “too sick,” to make life decisions, let alone care/treatment decisions. As I reflected on those responses, I wondered if we perpetuate helplessness with a paternalistic approach to care. When persons enter SUD care, they often feel defeated, and they do not trust their ability to make decisions given the status of their lives. Is it appropriate to reinforce this? I think not. I often help clients see that simply deciding to accept help demonstrates an ability to make sound decisions; that it takes courage and strength to accept help. I try to focus on strengths and abilities and help clients build self-efficacy. With this, I find that eventually clients feel empowered and ready to make more decisions. Clients can learn to trust themselves as persons who make mistakes, like everyone, and eventually they request and expect to be included in all decisions about their care.

Finally, patient/person participation, as the least represented category, in its absence made some subjects feel like their input into programming or care, was not valued. Subjects discussed providing feedback that was never addressed. Those subjects shared that giving feedback at the end of care did not help them reap the benefits of improvement while they were participating. In building a community, empowering people as they engage care, giving them a voice can be transformative, and is therapeutic in and of itself.

The absence of the four models and processes were indeed better accounted for by organizational stress and trauma and the absence of trauma-informed care in this study. In SUD settings where we are paternalistic in our clinical approaches, where we warehouse care and push people through generic and non-individualized interventions and curricula, where we shame people, remind and blame them for their mistakes, where the care is delivered in a space of micro and macro aggression even when we “mean well,” we are indeed continuing to cultivate a climate of toxicity, rather than sanctuary.

The subjects in this study shared their stories of arriving for help at the lowest moments of their lives, taking chances, trusting staff, placing their lives in the hands of others. All subjects reported debilitating shame with very little hope of improvement. Some subjects shared the ways they focused on the positive aspects of care and it seemed in some cases, subjects did not hold staff accountable for the way they, the subjects, were treated. Instead, subjects blamed themselves believing they deserved to be treated as though they were flawed and incapable of change or growth. In the sharing of their experiences, subjects’ beliefs about what they experienced fluctuated between believing they deserved poor treatment, and not believing it was appropriate. In other words, some of the experiences reported by subjects they believed they deserved, and other experiences they believed they did not deserve, nor were, they appropriate or

justified. This reported differentiation in experiences seemed to be contingent on the degree of shame that resulted from a specific experience. If subjects felt shame, they believed they deserved poor treatment. If subjects felt anger, especially when witnessing poor treatment of others, they believed it was unacceptable. At least two subjects shared that they were so traumatized by the care experience, and further had not learned any new coping skills, that they used or “got high” as soon as they left treatment. This is not uncommon and unfortunately, we often blame the client by saying “they just weren’t ready.”

In the current study, subjects reported some staff made attempts to deliver care congruent with the models; care that was respectful, holistic, strengths-based, and client-driven. However, the care was negated when subjects experienced a manifestation of staff burnout, vicarious trauma, and organizational stress. Subjects reported they could tell when staff were under stress, burned out, pessimistic, or jaded. They made statements like, “They’ve seen a lot of people come through here.”

They talked about issues that might seem insignificant to staff, but are important to clients, such as receiving writing assignments, when they reported they learned better through reading. Several subjects reported feeling “lucky” when they encountered a staff member who treated them and others with dignity and respect. Some subjects shared experiences within care facilities that leaned heavily on the 12-Step model, without specifically addressing co-existing illness. Most pervasive in the current study, were subjects’ reports that they did not believe they could challenge any of what they experienced. Therefore, they did what was expected to complete the program. All but one subject experienced relapse after all care episodes they discussed.

While the current study included only 12 subjects, each subject had participated in several different residential programs (from one to “many”) over time. Throughout the interviews, they discussed their experiences with the most current residential care episode; however, frequently, they made comparisons to past episodes. Collectively, the 12 subjects in this study reported having participated in no less than 40 residential care episodes, in a variety of organizations over the course of their lives.

Organizational Stress and Trauma

How does organizational stress and trauma, and the absence of trauma-informed care happen? How do the flowing and peaceful waters of care become muddied by toxicity? I considered my own practice in working with persons with a lived experience of SUD. I thought about times when I lost clients to their addiction, and in their tragic passing I frantically combed over the care I provided, wondering if there was something I missed, should or should not have said or done. I vowed to myself to be more aware and intervene differently the next time, likely applying a more paternalistic approach based in fear despite my best intentions. I considered the ways my practice reflected a medical model of care with a focus on pathology after many years of identified behavioral patterns exhibited by clients, and how much easier it was to create non-collaborative care plans that addressed that pathology.

I thought about my own vicarious trauma and how often that informed my work, with and without my awareness. I considered the bureaucratic systems I worked in, limited staffing and resources, and obstacles to the kind of care of which I could feel proud. I reflected on times when I did not have access to appropriate consultation when working with clients who coped with their complex trauma by using substances, and how often I had to simply hope for the best. All of this, on a good day, when my own personal life was manageable.

As a seasoned practitioner, with over 16 years of clinical social work practice experience, I am fully aware that even those of us with the best intentions make mistakes when we work with clients who need a great deal of help and support, and our resources are limited. Admittedly, good, kind, talented people in the wake of organizational trauma and other stressors begin to provide ineffective care or, worse, become abusive toward clients.

Through her many years of experience with the topic of organizational stress, Sandra Bloom, M.D., writes extensively about the ways that organizational stress presents as a barrier to service delivery, especially for clients who have experienced a high degree of trauma in their lives (Bloom, 2010). Bloom discusses the strategies employed by clients to distract from trauma, such as substance use, avoidance, and controlling behaviors. In a workplace that is ripe with organizational stress and trauma, it is not unrealistic to believe that staff have their own ways of dissociating and disengaging from the realities around them. Subjects in the current study expressed concerns about organizational stress and reported a variety of ways that staff disengaged from clients and other persons they observed.

In other literature, also referenced extensively by Bloom, the parallel process is discussed, which “has been defined as what happens when two or more systems – whether these consist of individuals, groups, or organizations – have significant relationships with one another, they tend to develop similar affects, cognition, and behaviors” (Smith, 1989, p.13).

When we consider the possibility that there are many people who work in the field of mental health who have experienced trauma, who may also be in recovery for SUD or other mental illness, or who are now re-traumatized by organizational stressors, it is not surprising to imagine that service delivery is naturally impeded as the systems continue to function in an unhealthy or ineffective state of parallel trauma. We understand this from an organizational

perspective; however, Bloom (2010) reports that the phenomena are underrepresented in social and mental health service literature.

Service delivery is especially impeded when we, as practitioners, are unaware of the degree to which the care we provide to clients is saturated by the trauma we also experience; hence, the lack of trauma-informed care. Bloom (2010) discusses the parallels of helplessness with hopelessness and the potential for staff to attribute their own helplessness to clients. It is as if the entire mental health care system is broken, we too are broken, and we fail to recognize the ways that the delivery of fractured care negates the basic tenets of recovery model, including “hope, strengths, respect, person-driven, addresses trauma, and holistic” (SAMHSA, 2012, p. 1). When our clients remain in care for a length of time, as with residential SUD care, they are at a greater risk of experiencing re-victimization and re-traumatization, as a direct result of organizational stress. Given that the literature is extensive with regard to organizational stress, burnout, and vicarious trauma, and the ways such issues affect the worker, it behooves us to consider the funneling down of these impairments to clients, and the subsequent impediment to the delivery of user-involvement/oriented models and processes of care.

How Do We Address These Concerns?

Bloom’s research helps us to understand that while there is a parallel process of illness in the form of organizational stress and trauma, there is a parallel process of addressing it while we simultaneously care for our clients (Bloom, 2010). The process begins with awareness of the issues, including a professional and moral obligation to work through our own trauma and pain, regardless of the source. Rather than ignoring, or denying the multiple ways in which our own personal trauma and organizational trauma impedes care, we should address it with our clients in a transparent and authentic way.

In her work on relational social work, Carol Tosone (2006) writes about the therapeutic relationship and introduces the term “shared trauma” when she discusses the experience of living through 9/11 and having to care for others as a practitioner, while caring for herself (p. 91). In her article, Tosone discusses shared trauma as occurring with elements of vicarious trauma and in the presence of major traumatic events shared between clinician and client. While organizational stress does not necessarily qualify as a discreet and major traumatic event, significant trauma can occur in the context of client violence, suicide, overdose, or a myriad of other issues that might be witnessed by providers and clients during residential SUD care (or any inpatient care episode). Therefore, the literature on shared trauma informs our work and contributes to our understanding of how we might simultaneously cope, heal, and thrive in a way that we would desire for our clients.

The work of Judith V. Jordan (2010) in relational-cultural therapy provides practitioners with a framework for the development of connection in the therapeutic relationship. I consider Jordan’s work when I think about the hierarchies of social service agencies and what Jordan describes as a “power over versus power with” dynamic (p. 24). When practitioners feel powerless and hopeless as staff of toxic agencies, the powerlessness and hopelessness is palpable by clients, as indicated by the data in the current study. Jordan (2010) discusses that we are all wired for connection, and her work translates well to the ways in which we can seek connection with our clients in the fostering of therapeutic relationships. Modeling the absence of hierarchy in an agency facilitates the absence of hierarchy in the therapeutic relationship, thus resulting in the connection so many of our clients seek, in addition to the work environment providers desire.

When considering the theoretical framework for the current study of person-centered care, Carl Rogers’ work helps us understand that the client and therapist, as a single organism,

move toward change only in the presence of trust (Rogers, 1962). Change occurs through the authentic relationship between client and therapist and the quality of the work is not contingent on training or education, but, instead, on the unconditional caring and positive regard for the client. What is modeled in a toxic agency is the opposite, and, if we are to affect change, it behooves us to identify ways to bring the experience of unconditional caring into the therapeutic relationship. Today's recovery model care is rooted in the philosophies of Carl Rogers, as mentioned earlier in this dissertation.

Heed the Recommendations of the Persons with the Lived Experiences

The current study finds the presence of organizational stress and trauma, and a lack of trauma-informed care not only serves as an impediment to the delivery of user-involvement/oriented care models, but becomes the overarching phenomena that informs our clinical work. To counter this, it is important to consider feedback from the subjects in this study. To the subjects in this study, what providers say and do *matters*:

- Input in a care plan matters. Helping people understand they are valued members of the team matters.
- Rewarding successes in care with "privileges" is paternalistic. Rewarding with responsibilities that empower is important for growth in recovery.
- Connection matters. Subjects discussed it felt safer to be honest with staff when they experienced a connection.
- The perception of powerlessness is palpable with phrasing like, "I didn't think I had a choice. I just did what I had to do to get through it."
- Help clients build confidence through a "power with" dynamic.

- Communities in care are built by patient/person participation. A sense of community builds connection. Connection fosters growth in recovery.
- Quoting statistics about relapse and death is not reflective of motivational interviewing, and subjects in this study reported it gave them a sense of hopelessness and was not person-centered.
- There is considerable shame surrounding SUDs. Subjects reported feeling shame, which can be countered by connection in the therapeutic relationship and the implementation of user-involvement models of care.
- Short-term goal achievement builds self-efficacy, which is lacking for clients when they enter care.
- Words spoken by staff were important to persons in this study; use of non-recovery language facilitates a negative care experience. Subjects discussed the importance of staff using positive and supportive language.
- Integrated care for co-existing illness was important to the subjects of this study. All reported struggles with mental illness and further, reported occasions where integrated care was limited, or non-existent.
- It was important to the subjects in the current study that staff were hopeful and not pessimistic.
- Telling people that “all they have to do is put in the work in recovery” is not reflective of a thorough understanding of the process of addiction or substance use disorder care.
- In the current study, subjects reported using substances after treatment to find relief from the treatment itself.

Chapter 5: Conclusion

The purpose of this study was to examine the experiences of residential SUD care participants with user-involvement/oriented models and processes of care, which are: (1) person-centered; (2) shared decision-making; (3) recovery model; (4) and, patient/person participation, including a synthesis of the models. The aim of the research was to expand knowledge regarding SUD care best practices by increasing awareness and understanding of the experiences of former residential SUD care participants with user-involvement models and processes of care. A secondary aim was to explore the existence of parallels that may exist between responses of former residential SUD care participants and findings of outcome studies of the models and processes in the literature. Finally, the study provided a forum for former participants of residential SUD care to discuss their experiences with the care models, where applicable.

The goal of the study was to provide a better understanding of the following: (1) Each user-involvement model and process as it relates to residential SUD care from the perspective of residential SUD care participants; (2) The importance of concretizing the concepts for future empirical studies; and (3) A nomenclature for the synthesis of the models and processes in order to inform future empirical studies and assist practitioners in the field with applying the concepts in a way that is congruent with the outcomes of empirical studies.

I expected that one or more of the models and processes would not be experienced by subjects. I expected this finding because of the limitations in resources for practice in the field. However, all subjects experienced varying degrees of the four models and processes (person-centered, shared decision-making, recovery model, and patient/person participation) including a synthesis of the models. In this study, the experiences reported by SUD care participants

suggests there are ways to implement the four models and processes, albeit in varying degrees despite limited resources.

An unexpected finding was that the delivery of the models and processes was impeded by the presence of organizational stress and trauma, and a lack of trauma-informed care. Subjects shared specific examples of experiences with the four models; yet, as the data were coded, the emergence of themes of organizational stress and trauma were clearly illuminated. The study results demonstrate that there is great potential in residential SUD care for clinical work to be negatively affected by organizational stress and trauma, and a lack of trauma-informed care.

Implications for Further Research

Bloom (2010), Jordan (2010), and Tosone's (2006) research lays the groundwork for understanding how organizational stress and trauma impede both the application of any or all of the four models of care and the effectiveness of SUD treatment. While Bloom's work identifies organizational stress and trauma and a lack of trauma-informed care as impediments, her work is not specific to SUD care, or even residential SUD, which is where clients and practitioners have a high degree of interface.

Tosone (2006) and Jordan (2010) discuss the importance of connection, which serves as a reminder that the therapeutic relationship is just as much a human relationship as it is clinical, implying that it is impossible for me to remove who I am and what I experience from therapeutic interactions with clients. Yet, there remain no specific studies exploring the impact of organizational stress and trauma, and a lack of trauma-informed care, on the delivery of user-involvement/oriented care models and processes in a SUD care setting.

Before we can evaluate the degree to which organizational stress and the absence of trauma-informed care impedes the delivery of user-involvement/oriented care models and

processes, we must first empirically evaluate SUD care outcomes based on a synthesis of the four models and processes. I recommend adopting “user-involvement/oriented care models and processes” as the terminology or nomenclature used to describe the presence of a synthesis of the four models and processes in residential SUD care. In the present study, residential SUD care participants discussed the importance of all four models and processes, where no one model was more important than another. If a synthesis of the four models and processes is important for enhancing residential SUD care outcomes, there should be a common language used to describe it. This common language could be carried forward from study to study, and if outcomes support a synthesis, this nomenclature could be adopted for practice.

Further empirical research would also evaluate specific outcomes of residential SUD care and the achievement of client-identified care goals following care delivered in a framework based on a synthesis of the four models and processes. Based on the current research, outcome studies may not be promising, unless the studies demonstrated that a synthesis of the models was delivered in the absence of organizational stress and trauma.

A mixed-methods study that includes measurable outcome data and a qualitative exploration of both clients’ and practitioners’ experiences with the four models and processes could provide a broader understanding of the importance of applying the four models to care. At that point, evaluating the presence and impact of organizational stress and trauma from the perspective of both the participant of care and practitioner could be beneficial.

It might also be important to determine which aspects of care provide the clients with the greatest experience of the four models and processes and which staff members provide the type of care indicative of the models. Put simply, further research should include the evaluation of the presence of a synthesis of the models in residential SUD care, and the variables that impede

their delivery, from the perspective of care participants and staff members. Potential variables are organizational stress and trauma, burnout, vicarious trauma, and evidence of a lack of trauma-informed care. Because of the potential for care to be delivered in the context of organizational stress and trauma, it is important in future research to evaluate the presence of organizational stress and trauma in the SUD program, and if determined absent, engage a study of outcomes based on a synthesis of the four models.

Implications for Social Work Practice

Even with the application of the most cutting-edge care and evidence-based practices, organizational stress and trauma and a lack of trauma-informed care exists. It begs the question, how much of the work is undermined by the presence of organizational stress and trauma? Are we, like so many of our clients, simply marking time in residential SUD care?

The outcome of the current study leaves lingering questions. What would be the outcome of care if it were infused with a full representation of the models and processes and if we consistently assessed and evaluated the models' presence and impact? How might people experience care under those circumstances, and what would be the care outcomes from a person-centered, goal-driven perspective? How might we ensure all levels of care are representative of a synthesis of the models and processes? Based on the current study, none of the above questions could be answered before evaluating the degree to which a program is impacted by organizational stress and trauma. If organizational stress and trauma exists in a program, it would require intervention in the form of a complete overhaul of system processes in order to promote healing. In other words, the parallel process of repair for staff and clients must be engaged with a gradual introduction of best practices.

When we engage in the practice of micro and macro aggression towards clients, including the constant reminder of devastating statistics about relapse and death, we are feeding into our client's desperation in a very anxiety provoking way, which is contraindicated according to the literature. How do we instill hope in ourselves and our clients in the wake of organizational stress and trauma? Are we keeping clients in survival mode when they participate in care in a trauma-saturated environment? If so, how do we move them from survival to thriving? Are we, as practitioners, simply *surviving* in our organizations? How do we cross the threshold from toxic to healthy, applying care that is truly reflective of recovery model? Perhaps the answers lie in the packaging of our models and processes and the honest, and transparent, recognition of the impact of organizational stress and trauma on the care package as whole.

Until research emerges to guide practice in trauma-informed residential SUD care, it is important to take the initiative as practitioners to recognize our own impediments to quality care delivery. We can do this through training on organizational stress and trauma, trauma-informed care, vicarious trauma, and burnout. We can be advocates for trauma-informed care in our work environments, become subject matter experts of the concepts and provide training within our organizations. We can be honest with ourselves about what informs our work and seek our own help and consultation accordingly.

As we learn about the efficacy and importance of care delivered based on a synthesis of user-involved/oriented care models and processes, we can educate ourselves on impediments to that service delivery, and those processes that enhance implementation of the models. Perhaps we seek out new research that helps us to counter our experiences with organizational stress and trauma, and a lack of trauma-informed care.

Although new phenomenon and studies of vicarious resiliency are beginning to emerge a recent study found that vicarious resilience helped practitioners intervene in the presence of clients' traumatic experiences (Hunter, 2012). In her work, Hunter (2012) found that therapists who built connections with clients were able to move through the vicarious trauma to vicarious resilience in the process of shared empathy, similar to the tenets of relational-cultural therapy described in Jordan's work (2010). Jordan (2010) also reminds us healing takes place in connection, and, rather than avoiding or dismissing clients as they re-enact or describe trauma that unknowingly reminds us of our own, the power of connection is the place from which healing is born.

Where once there was a parallel process of shared trauma, we can begin the process of healing through a parallel process of shared empathy with our clients. Vicarious trauma becomes vicarious resilience, and compassion fatigue becomes compassion satisfaction. As social workers, when we advocate for ourselves in our organizations, we are advocating for clients. We are advocating for care that is trauma-informed, fully aware of the debilitation and contagion of trauma that is ever present in social service agencies.

As a field of SUD care practitioners, we seek to help our clients experience a successful care outcome. In the current study, subjects reported successful care outcomes for having completed care despite the presence of organizational stress and trauma, and a lack of trauma-informed care. I would say that is indeed successful, and quite a feat. Yet, it begs the question regarding what *change* has really taken place when long-term goals such as abstinence or harm reduction are not achieved and desired. If we want to help people make *and* sustain the changes they desire, we must be honest about what informs our work and the values of the organization

where care is delivered. What is more, we must face that our client's healing, health, and wellness are contingent on our own.

Limitations of this Study

My 16 years of clinical social work practice, primarily with veterans, service members, and their families, informed my literature review. Therefore, the basis of the literature review incorporated my practice frame, which is not representative of a global or international understanding of SUD care captured by international practice literature.

In coding and analyzing the data, a point of saturation occurred with a small sample size. It may be of benefit to explore this topic using a mixed-methods approach with a greater number of subjects, including both men and women. The current study might have demonstrated more rigor with the use of additional coders or the implementation of qualitative study software, and an equal number of male and female subjects.

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Appendix A

Questions and Criteria

Inclusion Criteria

- Adults age 18 and over whom have completed at least one residential SUD care/treatment program (short-term, 30 days or fewer of non-acute care, long-term, 30 days or more, hospital residential in a 24-hour medical care facility, excluding detoxification) within the past two years (2014-2015). The purpose of narrowing the dates of participation is to obtain subjects with recent participation and increase the likelihood of exposure to new or empirically represented models of care. **(These criteria were changed to include all residential SUD care experiences during any time period).**
- The study will aim to include the same number of men and women and will explore the presence or absence of care differences based on gender, according to the subject's observation and report, if applicable.
- Program completions: Clinically driven termination, successful completion, goals attained.
- Diagnosis of at least one SUD (Substance Use Disorder) as defined by the Diagnostic and Statistical Manual of Mental Disorders 5 (American Psychiatric Association [APA], 2013), at the time of admission to residential SUD care.
- Persons with a diagnosis of SUD and other co-existing illness will be included in the study. Any diagnostic presentations will be considered; however, the subject must have at least one SUD diagnosis/reported concern.

Exclusion Criteria

- Minors (age 18 and below)/the subject must have participated in care after the age of 18. It is my intent to include in the study the experiences of individuals with vulnerabilities from co-existing illnesses, including SUDs (see inclusion criteria). Excluded from the study are individuals with the following concerns:

- Individuals who report safety concerns, such as suicidal or homicidal intent or plan at any time during interaction with the interviewer.

Should it appear that a subject is experiencing difficulty managing his/her emotions, I will inquire about safety risks, and if reported will stop the interview and assist the subject by contacting first responders. If the subject denies imminent safety risks, the interview will proceed. If the subject reports difficulty managing emotions as a result of the content of the interview, I will inquire about his/her ability to continue and will stop the interview as needed.

- An individual experiencing acute psychosis may be able to participate in the study and will be considered on a case-by-case basis.

For example, it may be part of an individual's lived experience to hear voices and this alone may not prevent participation. However, interviews will not take place with individuals whose thought processes are too impaired for them to follow the interview.

- Individuals who appear to be under the influence of a substance will not be interviewed.

If a subject reports or appears to be in need of therapeutic assistance, I will assist by helping the subject explore options for appropriate referral services.

- Non-English speaking individuals will be excluded from this study.

Orientation to the Interview

1. Review interview process and Informed Consent (Penn Consent Form).
2. Ask what questions interviewee has about the interview.
3. Review guidelines for audiotaping.
4. Review guidelines for compensation.

Face-Sheet Data

I will solicit the demographic information from each subject and explain the categories and information using common language in layperson terms.

1. Name
2. Gender (as identified by subject)
3. Age (age of subject in years)
4. Race or Ethnicity (in subject's own words)
5. DSM 5 Diagnosis/diagnoses (if known) and/or concerns that led to care
6. Total Number of Residential Care Stays and dates (The residential care categories are defined by SAMHSA in the Treatment Episode Data Set (TEDS) 2000-2010, National Admissions to Substance Abuse Treatment Services (<http://media.samhsa.gov/data/2k12/TEDS2010N/TEDS2010NWeb.pdf>, 2012, p. 39)
 - a. Short-term (30 days or fewer of non-acute care)/Dates/Type of Termination (such as completed, dropped out)
 - b. Long-term (30 days or more)/Dates/Type of Termination
 - c. Hospital residential in a 24-hour medical care facility, excluding detoxification/Dates/Type of Termination
7. Most Recent Care Mandated or Voluntary
8. Name and location of residential facility (This information is used to explore and report differences in care settings, such as those publicly or privately funded.)
9. Subject's Employment Status
10. Funding Source for Care
11. Setting and Location of Meeting with Subject

In-depth Interview (Initial Questions Interviews 1-4)

- A. The following questions are about the most recent treatment/care program that you participated in. **(TIMEFRAME REMOVED AFTER INTERVIEW 1)**
1. When you entered the program, how ready were you to make changes? (Recovery Model, Person-Centered)
 2. In what ways, would you say the staff respected your readiness for change? (Recovery Model, Person-Centered)
 3. How were the goals created? (Person-Centered, Therapeutic Alliance, Shared Decision-Making)
 4. How were your groups and classes selected? (Person-Centered, Therapeutic Alliance, Shared Decision-Making)
 5. At which point(s) during your care did the staff ask about your needs? (Recovery Model, Person-Centered)
 - a. How were your needs incorporated into your care?
 6. At which point during your care did the staff ask about your care preferences? (Recovery Model, Person-Centered)
 - a. How were your preferences incorporated into your care?
 7. In what ways would you say your cultural values were incorporated into your care? (Recovery Model)
 8. How involved in making decisions about your care were you? (Shared Decision-Making)
 9. How involved did you want to be in making decisions about your care? (Shared Decision-Making)
 10. Please describe your relationship with the counseling staff. (Person-Centered, Therapeutic Alliance, Recovery Model)
 - a. In what ways did this affect your care?
 11. Please describe how hopeful you felt about your situation improving while you were in care/treatment. (Recovery Model)
 12. In what ways did staff show they were hopeful for you during your care? (Recovery Model)
 13. How confident did you feel with yourself during your care? (Recovery Model)

14. In what ways did staff show they were confident in you during your care? (Recovery Model)
15. In what ways did staff include your support systems (family, church, community, etc.)? (Recovery Model)
16. In what ways did the staff include you in the evaluation or improvement of the program? (Examples, committees, forums, town halls, focus groups, feedback questionnaires, etc.). (Person/Patient Participation)
17. In what ways would you have wanted to participate in evaluating or improving the program? (Person/Patient Participation)
18. What was the outcome of your care?
 - a. How did this compare to what you expected?
 - b. How did this compare to what the staff expected?
19. What contributed to that outcome?
20. What has been your experience with lapse or relapse since you finished the program?

B. Wrap Up

1. If you could make any recommendation for improving the program you completed most recently, what would it be?
2. Is there anything else that you think I should know about your last or most recent care/treatment program?

In-depth Interview (Reconstructed Questions Interviews 5-12, 14 May 16)

A. The following questions are about the most recent treatment/care program that you participated in.

1. When you entered the program, how ready were you to make changes? (Recovery Model, Person-Centered)
2. In what ways would you say the staff respected your readiness for change? (Recovery Model, Person-Centered)
3. How were the goals created? (Person-Centered, Therapeutic Alliance, Shared Decision-Making)

What were your goals (**Added after interview #1, if not included in response**)

4. How were your groups and classes selected? (Person-Centered, Therapeutic Alliance, Shared Decision-Making)
5. At which point(s) during your care did the staff ask about your needs? (Recovery Model, Person-Centered)

How were your needs incorporated into your care?

6. At which point during your care did the staff ask about your care preferences? (Recovery Model, Person-Centered)

How were your preferences incorporated into your care?

7. In what ways would you say your cultural values were incorporated into your care? (Recovery Model)
8. How involved in making decisions about your care were you? (Shared Decision-Making)
9. How involved did you want to be in making decisions about your care? (Shared Decision-Making) – **Probed more deeply as subjects discussed varying interest in participating**
10. Please describe your relationship with the counseling staff. (Person-Centered, Therapeutic Alliance, Recovery Model)

In what ways did this affect your care?

The following added for interviews 5-12, based on coded data interviews 1-4

11. When staff were the best, or really helpful, what made them helpful? (Org trauma, burnout, vicarious trauma)

When staff were not so great, or the least helpful, what made them unhelpful?

12. What stories did staff share, horror stories, or statistics about the outcome of addiction? (Org trauma, burnout, vicarious trauma)

How about other bad outcomes? (Getting to context of this sharing)

13. Did staff ever seem worried for you? (Vicarious trauma)

What do you think worried them?

14. Did you ever witness conflict between staff? (Org trauma, burnout, vicarious trauma)

(If so) What happened? How were you affected? Safety issues?

15. In what ways did staff seem stressed or overwhelmed? (Org trauma, burnout, vicarious trauma)

How could you tell? What was that about? (Probe as needed)

16. In what ways could you tell staff really enjoyed their job? (Org trauma, vicarious trauma, burnout)

If they didn't how do you know?

ORIGINAL QUESTIONS CONTINUED

17. Please describe how hopeful you felt about your situation improving while you were in care/treatment. (Recovery Model)

18. In what ways did staff show they were hopeful for you during your care? (Recovery Model)

How successful did staff think you would be in recovery? (Scale 1-5) (Hope RM) Added

19. How confident did you feel with yourself during your care? (Recovery Model)

20. In what ways did staff show they were confident in you during your care? (Recovery Model)

If they did not seem confident, why not? As needed probe

21. In what ways did staff include your support systems (family, church, community, etc.)?
(Recovery Model)

How important was this for you? Added

22. In what ways did the staff include you in the evaluation or improvement of the program?
(Examples, committees, forums, town halls, focus groups, feedback questionnaires, etc.).
(Person/Patient Participation)

23. In what ways would you have wanted to participate in evaluating or improving the program?
(Person/Patient Participation)

How did this affect your care? Added as needed

24. If you could have made recommendations for improving the program what would they have been? (PP) Added

25. What was the outcome of your care?

What do you think contributed to that outcome? (As needed probe)

26. What that the outcome you expected (why, why not)?

Was it what staff expected for you?

27. What has been your experience with lapse or relapse since you finished the program? (After program?)

B. Wrap-Up

Is there anything else that you think I should know about the program that I did not ask?

Appendix B

IRB Approval and Mandatory Consent

University of Pennsylvania

Office of Regulatory Affairs
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INSTITUTIONAL REVIEW BOARD
(Federal-wide Assurance # 00004028)

22-Feb-2016

Richard Gelles

SSW RESEARCH LAB

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arnettk@sp2.upenn.edu PRINCIPAL : RICHARD GELLES

INVESTIGATOR

TITLE : User-Involvement/Oriented Care
Models and Residential Substance
Use Disorder Care

SPONSORING AGENCY : NO SPONSOR NUMBER

PROTOCOL # : 824366

REVIEW BOARD : IRB #8

Dear Dr. Richard Gelles:

The above referenced protocol and was reviewed and approved using the expedited procedure set forth in 45 CFR 46.110, category 7, on 2/19/2016. This study will be due for continuing review on or before 18-Feb-2017.

Approval by the IRB does not necessarily constitute authorization to initiate the conduct of a human subject research study. Principal investigators are responsible for assuring final approval from other applicable school, department, center or institute review committee(s) or boards has been obtained. If any of these committees require changes to the IRB-approved protocol and informed consent/assent document(s), the changes must be submitted to and approved by the IRB prior to beginning the research study.

If this protocol involves cancer research with human subjects, biospecimens, or data, you may not begin the research until you have obtained approval or proof of exemption from the Cancer Center's Clinical Trials Review and Monitoring Committee.

The following documents were included in this review:

_HSERA Initial Expedited Review Submission (confirmation code: cabbhhed), Submitted on: 02-03-16

_Dissertation Timeline, uploaded 01-24-16

_Recruitment Flyer, uploaded 01-24-16

_Informed Consent Form, uploaded 01-24-16 _Cover Letter, dated 01-24-16

When enrolling subjects at a site covered by the University of Pennsylvania's IRB, a copy of the IRB approved informed consent form with the IRB approved from/to stamp must be used unless a waiver of written documentation of consent has been granted.

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website: <http://www.upenn.edu/IRB/directory>.

Thank you for your cooperation.

Sincerely,
David Heagerty
IRB Administrator

Appendix C

Research Flyer

I Want to Hear About Your Residential Treatment Experience!



Volunteers needed for research project exploring people's experiences with residential substance use disorder treatment.

You qualify for the study if you...

- Are 18 years or older.
- English speaking.
- Have at least one substance use disorder.
- Have successfully completed at least one residential treatment program.

What do you have to do?

- Respond to questions during a guided interview with the researcher, a University of PA, School of Social Policy and Practice Doctoral student.

How long does it take?

- This depends on you. I'm interested in your treatment experience(s) and we may spend anywhere from 1-2 hours together.

What will I get for participating?

- You will receive \$10 at the completion of the interview.

Your shared experience will help us understand what is important to people who go to treatment.

If you are interested, please contact Kathryn at 717-919-9524, or ksocwk@yahoo.com

Appendix D

Advertising Tracker 1

23 Feb 16 - FB Sent to Friends: 24 Feb 16 4 Friends		AA	NA
		Date	Date
		Posted	Posted
AA	NA		
15120 Turkey Foot Rd. Darnestown, 20878	11900 Darnestown Road Gaithersburg, Maryland 20878	28-Feb-16	28-Feb-16
119 N. Frederick Ave. Gaithersburg, 20877	12801 Darnestown Road Gaithersburg, Maryland 20878-3519	28-Feb-16	28-Feb-16
610 S. Frederick Ave. Gaithersburg, 20877	13 Firstfield Road Gaithersburg, Maryland 20878-1700	28-Feb-16	28-Feb-16
Md. Rt. 355 & Summit Ave. Gaithersburg, 20877	9901 Medical Center Drive Rockville, Maryland 20850	28-Feb-16	Called
431 N. Frederick Ave. Gaithersburg, 20877	15932 Shady Grove Road Unit B Gaithersburg, MD 20877-1314	28-Feb-16	28-Feb-16
S. Frederick & Westland Dr. Gaithersburg, 20877	11810 Falls Road Potomac, Maryland 20854	28-Feb-16	28-Feb-16
Rt.355 & Westland Dr. Gaithersburg, 20877	215 West Montgomery Avenue Rockville, Maryland 20850-2804		28-Feb-16
15932 Shady Grve Rd, B Gaithersburg, Maryland 20877	9801 Centerway Road Montgomery Village, Maryland 20886	28-Feb-16	28-Feb-16
16420 S. Westland Dr Gaithersburg, 20877	8200 Emory Grove Road Gaithersburg, Maryland 20877	28-Feb-16	28-Feb-16
Waring Station Rd. Germantown, 20874	112 West Montgomery Avenue Rockville, MD 20850		28-Feb-16
810 S. Frederick Ave Gaithersburg, 20877	19951 Father Hurley Blvd Germantown, MD 20874-1003	28-Feb-16	28-Feb-16
26 N. Summit Ave. Gaithersburg, 20877	8201 Emory Grove Road Gaithersburg, MD 20877-3738		

111 Central Avenue Gaithersburg, 20877	608 North Horners Lane Rockville, Maryland 20850	28-Feb-16	28-Feb-16
303 Chestnut Ave. Gaithersburg, 20877	1251 1st Street Rockville, Maryland 20850		28-Feb-16
100 Welsh Park Dr Rockville, 20850	355 Lithicum Street Rockville, Maryland 20851	28-Feb-16	28-Feb-16
215 W. Montgomery Ave. Rockville, 20850	12319 Washington Avenue Rockville, Maryland 20852-1803	28-Feb-16	28-Feb-16
19951 Father Hurley Blvd. Germantown, 20874	11418 Old Georgetown Road Rockville, Maryland 20852-2859	28-Feb-16	
	4629 Aspen Hill Rd Rockville, Maryland 20853		

Appendix E

Advertising Tracker 2

Appendix E Contact Tracker Kathryn D. Arnett	
STOPS	DATE
VFW	
211 N Frederick Ave Ste K Gaithersburg, MD 20877-2434	5-Mar-16
11511 MacArthur Blvd Potomac, MD 20854	5-Mar-16
LEGION	
Address: 19401 Walter Johnson Rd, Germantown, MD 20874	5-Mar-16
CALLS/EMAILS	
Kolmac Clinic (DC, Silver Spring, and Gaithersburg)/Emailed POC's/Directors	29-Feb-16
Emailed Addiction Treatment Services, Walter Reed, Clinical Director	29-Feb-16
SMART MEETINGS	
St. James Episcopal Church	No Resp.
Suburban Hospital Addiction Treatment Center	4-Mar-16
	4-Mar-16
Prince of Peace Lutheran Church	
	4-Mar-16
INPATIENT PROGRAMS	
Mountain Manor Mailed Information	3-Mar-16
Phoenix House	2-Mar-16
Salvation Army/Harbor Light Tx Center 202-269-6333	No Resp.
Serenity Acres	3-Mar-16
Margaret Hawk	3-Mar-16
Mission Ridge/OPT Counseling - no SUD Clients	REFUSED
The Bergand Group - Professional Recovery Partners 410-504-1764	
	3-Mar-16
The Retreat at Sheppard Pratt Emailed (from online)	3-Mar-16
Maryland Addiction Recovery Center Emailed from online	3-Mar-16
Father Martin's Ashley Email from online/EMAIL BOUNCED	3-Mar-16
Retreat at Lancaster Co	8-Mar-16
Foundations Recovery Center	3-Mar-16
Pocono Mountain Treatment Center by email on line	3-Mar-16
Roxbury Treatment Center	4-Mar-16

House of Ruth	3-Mar-16
My Sisters Place (by email)	3-Mar-16
Calvary Women's Shelter by email	3-Mar-16
Green Tree Shelter 301-365-4480/Nat'l Center for Children/Families	
kbetzer@nccf-cares.org	8-Mar-16
DSW COHORT	4-Mar-16
Catholic Charities 301-942-1790, 202-635-5900 (Share with Rehabs and Shelters)	No Resp.
Circle Treatment Center Gaithersburg 301-258-2626 (CALLED)	No Resp.
AA Gaithersburg 301-963-0340 (CALLED)	No Resp.
Sagebrush Treatment Center	7-Mar-16
SAMHSA Communication 240-276-2130	REFUSED
Treatment Advocacy Center info@treatmentadvocacycenter.org	7-Mar-16
Renfrew Center of Bethesda	7-Mar-16
Elements Behavioral Health 855-678-8337 (PA) Gave Information	8-Mar-16
Life Center at Galax (VA) THEY WILL CALL ME, CANNOT EMAIL THEM	8-Mar-16
INOVA Behavioral Health inovabehavioralhealth@inova.org	11-Mar-16
Rubicon admissions@rubiconrehab.org	11-Mar-16
Williamsville Wellness info@williamsvillewellness.com	11-Mar-16
Mount Regis Center 877-217-3447 (VA)	No Resp.
Gonzalez Recovery 772-633-1097 (Left Message)	No Resp.
CSB 703-383-8500	17-Mar-16
Poplar Springs 804-733-6874	No Resp.
Farley Center 866-470-9548	11-Mar-16
Bridging the Gaps 540-535-1111	17-Mar-16
Edgehill 540-662-8865 edgehillrecovery@comcast.net	17-Mar-16
The DC Center for LGBT supportdesk@thedccenter.org	17-Mar-16
Clean and Sober Streets	17-Mar-16
So Others Might Eat Inc (SOME)(202) 797-8806x1000 LEFT MESSAGE	No Resp.
New Start II Recovery House,	19-Apr-16

Appendix F

Subject Demographic Sheet

APPENDIX F Subject Demographic Sheet (PHI Redacted) Kathryn D. Arnett

Gender	Age / Yrs	Race/ Ethnicity	Diagnoses/Concerns (Subject's Words)	Total # of Tx/Dates	Type of Care	Type of Termination or Completion	M & V	Employment Prior to Care	Care funding source	Dual	Relapse after Tx
Male	44	Caucasian	Alcoholism	1 - 12/18/05-1/19/06 32 Days	Short-Term Residential/ 30 days or less (2 days admin)	"Successful Discharge"	Voluntary	Unemployed	Insurance and Private Pay	Yes, Depression and Anxiety	No, 10 year sober (AA)
Female	55	Caucasian	Alcoholism	9 - Dec 2013-Jan 2014, Apr & Oct 2012, Dec 2011, May 2011, Jun 2010, Jan 2010, Nov 2010/not finished, Mar 2009	Short-Term Residential/ 30 days or less	Successful completion all except 1	Voluntary all	Unemployed	Insurance and Private Pay	Depression	Not after last Tx
Male	35	Caucasian	Heroin	1 - Nov 06 - Jan 07 (90 days)	Long-term/30 days or more	Successful completion	Voluntary	Unemployed	Insurance and Private Pay	Depression	Yes, Currently OPT
Male	65	Black	Alcohol & Cocaine	3 - Most recent May-Jul 09 (two months)	Long-term/30 days or more	Successful completion	Voluntary	Service-Connected Disabled Veteran	VA/free w/service-connected disability	Yes, Depression and Anxiety	3 years sober, relapse
Male	53	African American	Schizophrenia, Depression, Alcoholic	10 - Most recent Jan-Feb 2016	Long-term/30 days or more	Successful Completion	Voluntary	Unemployed	Public Assistance	Yes	Yes
Male	54	Black	Crack Cocaine, Depression	5 - Most recent Jan-Jul 2013	Long-term/30 days or more	Successful	Voluntary	Unemployed	State	Yes	Yes
Male	45	African American	Crack Cocaine, Alcohol, Major Depressive Disorder	3 or 4 - Most recent Dec 2011-Jul 2012	Long-term/30 days or more	Successful	Voluntary	Unemployed	State	Yes	Yes
Male	34	Mixed Columbia n and Black	Benzo Dependence, Polysubstance, PCP Dependence, Psychiatric Issues	3 - Most recent Dec 2015-Jan 2016	Long-term/30 days or more	Successful	Voluntary	Volunteer	Community Behavioral Health	Yes	Yes
Male	46	Black	Heroin, Depression, and Anxiety Disorder	5 - Most recent May-Jun 2015	Short-term/30 days or fewer	Successful	Mandated	Unemployed	Community Behavioral Health	Yes	Yes
Male	50	African American	Crack Cocaine, Alcohol, Schizoaffective, PTSD, Depression, Antisocial Personality Disorder	4 - Most recent May-June 2012	Short-term/30 days or fewer	Successful	Voluntary	Unemployed	Behavioral Health Services Inc.	Yes	Yes

Male	24	Caucasian and Jewish	PTSD, Depression, Anxiety Disorder, Bipolar, ADHD, OCD, Crack Cocaine, Xanax, Klonopin	1 - Most Recent 19 Aug 15 - Jan 2016	Long-term/30 days or more	Successful	Voluntary	Unemployed	Community Behavioral Health	Yes	Yes
Male	51	African American	Dual diagnosis, marijuana with crack cocaine and alcohol, mental issues	Many Times - Most recent May 2014-Feb 2015	Long-term/30 days or more	Successful Completion	Voluntary	Unemployed	State	Yes	Yes

Appendix G

IRB Approved Consent

University of Pennsylvania Informed Consent Form

Title of the Research Study: Examination of User Involvement Care Models in Residential Substance Use Disorder Care

Protocol Number:

Principal Investigator: Kathryn Arnett, 717-919-9524, ksocwk@yahoo.com

Co-investigator: N/A

Emergency Contact: Dr. Richard Gelles, gelles@sp2.upenn.edu

You are being asked to take part in a research study. This is not a form of treatment or therapy. It is not supposed to find something wrong. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision, you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if decide to participate. The principal investigator/researcher is going to talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends, or anyone you choose who can help you make a decision about participation.

If you do not understand what you are reading, do not sign it. Please ask the principal investigator/researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

What is the purpose of the study?

The purpose of the study is to examine and learn about individual's experiences with substance use disorder/addiction treatment/care. The explanation of your experiences will be used to complete my dissertation for Doctoral Studies in Clinical Social Work (DSW) at the School of Social Policy and Practice at the University of Pennsylvania.

Why was I asked to participate in the study?

You are being asked to join this study because you said that have completed at least one residential substance use disorder program within the last two years (2014 or 2015). The principal investigator/researcher would like to learn about your experiences in the program.

How long will I be in the study?

You are asked to participate in one interview, where the principal investigator/researcher will ask you specific questions about your participation in treatment/care. The interview may last between one and two hours.

University of Pennsylvania Informed Consent Form

Where will the study take place?

The principal investigator/researcher will interview you in a setting we both find acceptable, one that is private, quiet, where we are not likely to be disturbed. We can agree upon a day, and time of day, that is most convenient for you.

What will I be asked to do?

The principal investigator/researcher will interview you by asking you a series of questions related to your most recent experience in residential substance use disorder treatment/care. You will be asked to respond to those questions as thoroughly as possible.

What are the risks?

The risks of participating are minimal. You may feel uncomfortable with the questions, or they may cause you to reflect on situations that may have been unpleasant. In the unlikely event, you find what you discussed in the interview is upsetting to you after the interview is over, please contact the principal investigator/researcher. The principal investigator/researcher will help you identify resources for support or further assistance.

How will I benefit from the study?

Although being interviewed will not help you directly, it is possible that having a chance to share your story will be an interesting and possibly rewarding experience for you. Your participation could help us understand what individuals consider important in substance use disorder treatment/care, which can benefit you indirectly. In the future, this may help other people receive the kind of care that they consider helpful.

What other choices do I have?

If you choose not to be in the study, no alternatives will be offered. Because this is not a treatment or service, there are no alternative treatments or services offered.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary.

There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future. No one will be upset with your decision. There are no negative consequences should you choose not to participate.

When is the study over? Can I leave the study before it ends?

This study is ongoing; however, your role in the study ends as soon as the interview ends. The study may be stopped without your consent for the following reasons:

University of Pennsylvania Informed Consent Form

- o The researcher believes it is best for your safety and/or health-you will be informed of the reasons why
- o You have not followed the study instructions
- o The researcher, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future care, or any care you are currently receiving unrelated to this study.

If you no longer wish to be in the research study, please inform the principal investigator/researcher at any time before or during the interview.

How will confidentiality be maintained and my privacy be protected?

We will do our best to make sure that the personal information obtained during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

The information you share will be kept strictly confidential. The principal investigator/researcher will not share information about whether or not you have participated in this study with anyone outside of the University. Your name or other personally identifiable information will not be used publicly, and will not be shared with anyone not affiliated with this study. The principal investigator/researcher will use an audio recording device to record the interview. Only persons affiliated with the research within the University will have access to the audio recording. During the interview, the principal investigator/researcher will record your responses in order to stay focused on what you are saying. The recording will be used to review your responses and record them accurately. The principal investigator/researcher may take brief notes as you are talking. None of the data collected will be shared with anyone who is not affiliated with the University of Pennsylvania, School of Social Policy and Practice.

Will I have to pay for anything?

There is no cost to you for participation in this study. We will meet in a place that allows free public access to ensure there are no costs related to this study.

Will I be paid for being in this study?

You will be paid \$10.00 cash for your participation in this study.

Whom can I call with questions, complaints or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you

should speak with the principal investigator/researcher listed on page one of this form. If he/she cannot be reached or you want to talk to someone other than the researcher, you may contact the Office of Regulatory Affairs with any question, concerns, or complaints at the University of Pennsylvania by calling (215) 898-2614.

When you sign this document, you are agreeing to take part in this research study. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject _____

Print Name of Subject _____

Date: _____

Appendix H

Presence of Recovery Model

Presence of Recovery Model (SAMHSA's 10 Guiding Principles: Hope, Relational, Person-Driven, Culture, Many Pathways, Addresses Trauma, Holistic, Strengths/Responsibility, Peer Support, Respect)

very open
 focus on strengths of a person
 these are professionals they know what they are doing
 trusted they were able to take care of me
 warm relationship with counselor
 he was very good trusted and respected him
 community between patients and staff
 open communication back and forth
 community felt like family
 connection amongst staff and patients
 encouraged you to work harder for yourself
 counselor saw I was honest
 showed me I was doing well
 people who struggled were still encouraged
 same love and attention from staff
 not doing well still got the same care
 they didn't give up on you
 staff always encouraging
 staff believed I had a good chance
 counselors believed I could make it
 thought I was prepared
 staff very hopeful I would put it into action
 staff confident in me
 we were all a community
 we helped each other
 we role modeled for one another
 we helped one another
 important to be open
 community focus is important
 we help one another and pitch in on the unit
 that sense of community translates when you leave
 build support
 Holistic care looked at my whole life
 Heavy focus on cultural values, integrity and honesty
 Following through with what you say you're going to do
 Treated everyone the same
 They expect everyone to complete successfully, walk out and stay sober
 Even if your behavior is you're not ready, staff conveys optimism
 It's the staff job to be positive

Want people to be successful
 May not think they will be but want them to be
 Staff were younger—older staff were like peers
 They expect everyone to walk out and not take another shot
 They're very hopeful
 They talk like you're not going to pick up
 They assume you'll abstain and be successful
 My counselor was not an addict or alcoholic but she was helpful and effective
 Staff was confident in me
 They had an upbeat attitude
 Counselors were awesome even with people in trouble
 they were there for you
 if we had a problem we talked
 they're not doing it for the money or glamour, they want to help you
 they made themselves available
 all the staff were there for you
 Expect you to abide by the rules
 Staff talked like it was going to be successful
 I was there with peers of the same social class, we were all the same socioeconomic class
 People who were there liked me
 I was honest with my individual counselor
 We got along well
 He treated me with respect
 He was a good guy
 My counselor always had good things to say
 My individual counselor wanted me to do well when I left
 If counselor did know the answer he was honest
 my counselor was probably happy I finished
 he was probably pulling for me the whole time
 Group oriented
 As I was there longer started to get jobs and worked my way up
 The more responsibility they would give you as you've proven yourself
 They received me with open arms
 I was accommodated for care despite health issues/staff visited me in the hospital
 You're not your illness
 I was assigned a recovery coach who was also in recovery, she guided me along
 I could always return to treatment
 They were professional people there to help us not just as Vets but as human beings
 There's a couple of facilitators I got pretty close with
 We were able to identify
 Staff were there to help to the best of their ability
 They were willing to assist me with my goals
 Social workers were very helpful
 Staff believed I had potential
 those folks were encouraging me most of the time
 I'd give them a thumbs up

I really felt a dedication from those folks more so than in other programs
 Staff recommended me for peer support specialist
 They took a special interest in individuals
 They took a special interest because we were all on the same page
 Staff were good at their job
 The peer counselor let me know you can do what you need to do
 Peer counselor knew how to get past hurdles and obstacles, and keep on moving
 Peer counselor had been through some things herself so we could get on the same page
 We could mesh
 Took interest in my growth
 They had been through some difficulties in life, were able to overcome
 The main theme you are not your illness
 Staff are there to help
 If you want it, you have to seek it out
 I wanted to live another way of life, more positive way of life
 The class with the psychologist was instrumental in help me take a look at myself internally
 I was able to address my mental health issues
 I could identify with individuals who had problems themselves
 I was able to get an understanding of SUD and MH issues
 Meetings, activities to enhance mind, body, spirit
 I had a routine of certain activities
 I had a schedule
 I fit in and felt like I was going to reach the goals I set
 I tried to give feedback to individuals in the program-boost them up
 It was going smooth
 Each day I felt more confident, but not too overconfident
 Program was pretty much standard a good program
 Detoxing and getting better change was happening
 Made me more hopeful
 Expected it to be thorough and it was
 I could always return
 They would ask at intake how I was raised, who raised me, what my likes were, what I disliked
 Their effort and doing the work, as far as the getting me placed, was excellent
 all the staff members that weren't my personal counselors were helpful in one way or another
 They were concerned as to my well-being
 I didn't run into somebody with a funky attitude or that was disrespectful to me. It didn't happen
 they were concerned and I respect that made the atmosphere hospitable
 They were concerned within their parameters
 They succeeded in achieving, getting me set up with certain things like medical appointments
 They showed me they was hopeful my counselor going the distance
 Letting me know that I can make it as long as I don't pick up a drink they always drove that
 home
 I was happy-- they gave me some love that I was lacking
 Staying clean and coming back after I succeeded, letting them know that I'm still clean, saying hi
 You can do whatever you want and succeed provided you don't pick up a drink
 I have confidence, let them know I have confidence in them

I was picked to serve sandwiches to the homeless outside of the program who are still out there
 and haven't woken up yet as far as getting treatment
 They expect for me to return and be successful, pay them a visit, say hello one of these days in
 the future dressed up smelling good, looking good, haircut
 They expect to see an individual who's been through their program come back months and
 months, maybe years later, and say hi and what that individual has achieved
 When I went there, it was like, "Welcome, welcome." I felt like-- I haven't had a hug in a long
 time, that's what they gave me a hug, that meant a whole lot to me
 Just gave me that warm hug, that, "You don't want nothing from me but we're here to help you."
 made me feel special
 They gave me a lot of love, a lot of love
 Classes, through one-on-one that we have with the counselors, and mostly groups
 They had confidence in me
 The way that they interact with us, a lot of times their smiles
 They way that they interact with us is to have fun, taking us out, or taking us to a different
 program on the outside
 It's more the respect that you get from the staff, I like it. I enjoyed it
 Demeanor, it means a whole lot. Their posture as well
 I felt very much hopeful because I knew that I had to do it for myself
 The staff was hopeful for me
 They gave me the feeling, they gave me the smiles, they cared, they sat down if they'd seen that
 the look on my face wasn't right, something's wrong with him. Let us see what we can do to help
 him
 At first, when you're going there, you think that you're confident, but you're not on a balance, but
 after a few days, they make you feel comfortable
 I felt very confident, they made me feel very confident, and they see something in me that I
 didn't see
 The staff were really good, they was compassionate, they were really helpful to me, I became
 close to them
 They shared part of their stories
 They didn't downgrade me
 I was really close to the doc, if I had any problems I would go talk to him
 I could go talk to the counselors or anybody, or I could talk to the peer specialist
 They would ask me how I was doing. I would ask them how they were doing. Yeah, it went both
 ways
 They was wide open, they was open, kind, they was caring, attentive to my needs
 They cared about what I was going through
 They'd let me know, every day, you got a friend
 It helped me, because they showed me that they cared
 It just wasn't a job to them to show me that they care on me becoming better. It wasn't just a
 paycheck. They was really into it. They cared
 the attention that they showed me. They showed me how much they cared about me
 When I did wrong they still helped me
 They wanted me to succeed
 They're very professional
 I was very hopeful

As long as I stayed on the right path, I knew that I would make it
 They were saying they knew I could do it
 I was very confident. Because I was listening, I was putting in the work
 They would talk to me. They were proud of me when I was leaving
 the culture aspect of it, they were always there to support me based on my track record of being
 in and out of the streets for so long
 they were *willing to allow me* to offer my prayers five times a day based on my religion even if it
 interfered with my group they allowed me to take maybe five, seven minutes to pray every day
 they helped me go through the discharge process, set up a discharge date, she asks you, "Where
 would you like to go? What do you want to do?"
 he was a recovering addict himself and basically he didn't sugarcoat any of our stuff at the time
 he could relate to us a little bit more
 Not necessarily just being a clinician, and ever going through drugs and alcohol himself, but
 being that he was in our shoes at that point in time, we could relate to him
 there were recovered addicts that worked at that facility, people that honestly just genuinely care
 about recovering addict to try to get themselves to the point where they can believe in
 themselves, that they can stay clean and sober
 they genuinely just cared about trying to help someone-- wanted to help
 I got the sense that they were genuine, they cared about my well-being
 I had an opportunity to change my life and they kept telling me that you know, "You can do this.
 You can do that. most importantly just don't pick up
 they would help me become hopeful
 the staff would sit down and talk to me and they were hopeful with me because I was hopeful
 with myself
 Went out of their way to try to understand and listen to what I was trying to say when I was
 expressing myself
 When we talk, I could talk to her freely, and she allowed me to be me, to try and work these
 things out within myself, I could sense she really cared
 I had groups, so I mainly got help through talking in groups, through clients, one-on-one therapy
 The people that run the groups, the therapists, they would listen
 My therapist was great
 asking how I'm doing, giving me suggestions, "Hey, maybe I think you should do this, give this a
 try," just caring
 making me feel comfortable, being nice to me, being genuine, not just seeming like you're just
 there for a paycheck
 Just showing me that this is what you chose to do this job for, to help me make me feel like
 there's hope, give me something
 There were some people in there that cared, very much cared
 They'd come in and just be positive, and just, "Good morning! How are you guys?" You could
 see it; they have a glow to them
 There were some people in there that truly enjoyed coming in there and trying to save one.
 One guy, he'd be like, "If I could save one person, at everything I say, that's good enough for
 me." You could see it. You could just see it
 I was pretty hopeless when I first got there, but I just kept striving and doing paperwork,
 worksheets, asking my therapist for more worksheets, and talking to him, and then I got better,
 and better, and better

I was worried that I wasn't going to have anywhere to live when I left, because that's what happened the last time. But I was here a lot longer this time, five months or something. It got better and better.

My therapist being like, "Keep praying, you're doing great. I'm so proud of you. I'm going to miss you when you leave."

The one guy, he brought in cakes and stuff. Whenever we'd go away, we'd have like a little get-together

Everyone in there said that they believed in me. Everybody. They said, "You got the world, you got this. I believe in you. You've come a long way." I had a lot of hopeful talk

You were 119 pounds when you came here, you look great now, I can see a glow in your face.

You're much happier. Just keep doing what you're doing and you'll be fine

They did everything they could do to accommodate me

I had doctors on hand, the doctors, they care for their clients

The staff, they're a lot of recovering addicts that came from where I'm coming from, but now are helping other addicts get it

The therapy, they try to educate you about the dangers and long-term use of drug use and everything

They don't down you

If you further need assistance, as far as housing, they're there to help

It gives you hope of being in the facility like, "Damn, maybe I did make the right choice"

You get a case manager who helps you with housing

It's family oriented you start rooting for one another; you start watching one another's back

Everybody wants everybody to succeed

You have one-on-ones, group therapy

They didn't make it hard. They didn't discriminate, I'm talking about for everything: skin, color, sex, none of that, they're professionals

I had good rapport, a good relationship, with the clients and with the staff once I got to know them and they got to know me

I'm sharing my wealth of experiences with the individuals that I live with and also my

counselors, and therapists, and doctors, so they'll know a little bit more about me

These doctors was there around the clock, even on the weekends. If anything is bothering you physically, they would address it

It was constant around the care work, and so you never got neglected

Whatever it may be, heroin, whatever this and that, but they explain to you in depth, "That's normal what's happening to you, but we can wean you off of it, but you still going to get the best care."

They have so much work to do, and they can't see everyone on a one-on-one individual basis because there's so many people there. But that's where the counselors and everything came in they understand what it's like to be in my shoes

It was family oriented, and that helps

Yeah, I've had staff say "You don't ever have to come back to a place like this." But that's keeping it real and keeping it green, but also still wanting me to do good while I'm there and never have to come back. But if I do come back, glad to see me. That's not that that's a good thing because you're back, but they remember you and it was love, so that's a good thing

Coming from where I am and now you're working it, you're staff, it makes it easier for me and you to get a rapport, because you keeping it green, you're telling me the dangers, but you're also telling me the rewards

They made it as homey as could be

Even if I wasn't confident in myself, they seen my attributes and qualities

They don't let you get down on yourself

They try to keep your chin up because it's a better thing

Every day is not going to be a peachy day, but we can work through it if you need to talk." That's what the one-on-one's there for

I just happened to be fortunate enough to go to one where it was a lot of love

There's not staff against clients, it's everybody here together

Just want everybody to do well to the best of their ability

They want everybody to do well and not have to come back through these doors

They don't just let you leave unequipped, or unmanned, offer outpatient

They would set you up with a program before you even left so when you got ready to leave, that part was already straight

They are graduates from the program or people that stayed there for so much time, and they just coming back to give the message and give you encouragement

They work with you to the best of their ability, and they even got some of the best people

Appendix I

Presence of Person-Centered Care

**Presence of Person-Centered Care (Is this large enough to be its own care delivery model?)
(Person-centered care is about understanding the strengths and abilities, as well as the needs and challenges, of each individual and understanding that individual's personal recovery vision—and then helping him or her to get the services and supports needed to make those hopes and dreams a reality. SNAP, and SOC)**

acknowledged readiness for change

felt supported

say you're doing well

can't believe changes you've made and point to certain things

asking if my needs were met

preference for counselors in recovery

preferences asked at intake

do I prefer male or female counselor

individualized care

how I learn best or how I best participate

tried to adapt to needs and preferences

I asked for dual care and saw a psychologist

Extra spiritual care, met with my spiritual counselor

Tailoring to my needs

readiness for change facilitates care planning

assigned work

My counselor gave me more to do

Knowledge and care built trust in the center

Made me excited to try recovery

Work with my depression and anxiety

Kept getting better with medication and therapy

Many care options

Met my expectations

Staff asked about needs in the beginning

Let you know if you need something you need to ask

Many ex-alcoholics and addicts get it-unless you've been there it's hard to describe

they always incorporated my needs – whatever you need

if there was something I needed the counselor helped

they asked about food and religious preferences

they want to accommodate you and always tried to help

Talked about stuff not related to drinking

I wasn't a first timer-I already knew what I couldn't do-I was a seasoned rehabber, they knew I knew the ropes

They knew I knew how alcohol effects the body, I was seasoned in the 12 steps

I talked about my relationship with my significant other with my counselor

He had a cerebral approach – I appreciated that

He worked with me

He respected where I was
 He worked with me
 Staff were supportive, that's why they're there
 Open to a lot of questions
 I really liked my counselor
 I would share more with my counselor, more comfort
 What I wanted to get out of treatment
 What I wanted to do after treatment
 Figuring out what care issues were underlying the addiction problem
 Individualized meetings with counselor
 Individual assignments
 AA and NA was voluntary I chose to go
 When I first got there they have touched on needs
 Anything I need that I didn't bring (basic needs, supplies, toiletries)
 Counselor asked me if I get thing more out of reading or if I'm an auditory learner
 Asked for preferences and the way I learn
 Preferences like when it came to how I comprehend things
 You formulate your ideas according to what you want to achieve
 I formulated what I wanted to do
 Needs are up to the individual
 Program held my interests in my day to day life
 You may have to indicate what your needs were
 Preferences were discussed during sit downs with the social workers
 Communicate what you need, whatever your goal and preferences are
 They were willing to help me find a place to live
 I pretty much got what I needed out of it
 I had pretty much set my own goals
 groups were very informative to me
 soon as I got there they asked me why am I here? What motivated me to come in? What are my goals so they could know what I needed to work on or what they needed to help me to work on
 I came through the door, they were asking me questions about my goals
 They had asked me what my goal is, I was undecided
 I was so confused, they sat me down and they gave me some time to think about what my goals would be and I came back with a solution
 They were always helpful as far as me trying to meet those goals.
 They asked me when it started off what are my needs. What can we do for you here
 What's my needs and I'll let them know and then they'll write them down and then we'll just go through the whole thing
 Because I can discuss things in a group but sometimes there are things that you might not want to discuss in a group setting. That's where the one-on-one come.
 if you need more you can ask for more time to sit with a counselor and they'll have it for you
 they asked me a lot of those questions, what was it like growing up, was you doing this, was you going to different day camps, was you riding bikes with friends, stuff like that
 if I needed to talk with somebody, somebody was always there
 always somebody available for me to go to if I need to talk to somebody
 They took time out

They understood how I felt
 They was always there for me, and that's what make me feel whole
 Once you see somebody that's in recovery, you can relate to them better
 Once you start talking, it doesn't stay bottled up. So, they help me a lot of times if anything is on my mind, I can just talk about it.
 my goals were for me to be able to just stay abstinent from drugs
 It was pretty structured. There was a lot of structure there, and that's what I needed at the time
 They helped me out when I was in a lot of trouble with the law
 I was going to court, they was writing letters, they got me off
 My needs, did I have to get any clothes, did I have any problems, any legal or medical problems
 They made appointments for me, and when it was time for my appointment, they took me
 I was probably controlling my treatment plan
 They sit down and talk to the counselor, the therapist and they ask you what did you want to do
 I had a lot of depression because of my using, I had anger issues, I have abandonment, stuff like that, molestation, and because of that they put me in DBT groups
 staff were very respectful because they would help me go through my process
 I had individual psychologists and therapists and I was able to get through
 Other than using drugs and alcohol, I had some issues internally about myself that I had to work on so they helped me with that
 housing was my biggest goal, and relapse prevention
 group forum with a facilitator and we would talk about the causes of why people so young choose to use, what are the consequences because of using, and I got a lot out of it
 I actually gained a lot of insight about mindfulness and how to manage my anger and my emotions without using
 they have a certain curriculum, where they have DBT classes, and then they have something called a core group
 I would always see the psychiatrist for medication
 they pretty much were always asking me about what do I need, like do I need this type of medication adjustment, do I need this class or that class
 they would ask me how they could better help my stay
 I would have actual time to sit down with my one-on-one psychologist or therapist and talk about my progress
 what do we want to do, we would do a mindful meditation, all types of stuff in a group
 they kinda understood that maybe it might be beneficial for me to stay away from the city for a while
 they took time out to listen to what I was going through at the time
 If I was getting irritated in a group I was able to step out
 the counselors always had what they call an open door policy which means I could just walk in and just put my stuff on the table and express what was going on with me for that day, made me not want to leave treatment of course
 if I needed some type of extra assistance or help they were always there to support me
 part of being in DBT as I had homework, I actually had a lot of stuff to do that was part of me engaging in my treatment
 You would sit down with a therapist, and he or she would ask you, "What are your short-term and long-term goals?"
 In the beginning during your intake, they ask you about your religious beliefs

Someone that's in recovery, they've been through it first-hand. Especially if they've had years clean, they're doing something right
I felt motivated by peer specialists
first they try to ask you, "What are your immediate goals? What are your short-term goals? What can we help you-- and how can you stay abstained from using drugs?"
if you choose not to participate or you're not feeling well, that's when the doctors will see you and try to talk to you
therapists, they have doctors, and they have counselors, and all of these people are there for the clients. They work for the facility, but they're there for the clients.
the most important part is you're getting help for your problems no matter what
You get a one-on-one therapist, and also you have a counselor. Say if you have legal matters, anything that they can help you with, they will go to bat for you
One of the first things they ask you about religion. Are you religious? What type of religion?
They try to accommodate you
People that are coming from where I'm coming from and they are on a different level now, turning their life around, and are giving back. It's a big preference

Appendix J

Presence of Shared Decision-Making

Presence of Shared Decision-Making (Process)

goals combination of standardized and individual
could get more added

I was heavily involved in care planning

You could be involved in putting things on the plan

Counselors were receptive to taking things off or putting them on hold

Told you can be as active as you want

We discussed adapting things

Wanted to be informed, notified

I wanted to be involved, voice my opinions

Wanted to be involved at least know what was going on

If I wanted to know why they would address that

Add things on my treatment plan

My counselor responded to my requests for additions to my treatment plan

Wasn't motivated to change much maybe add on but not change

Adding things to my treatment plan

Counselor gave me feedback

Counselor, staff, patients, help you figure out what's best for you and who is a detriment to your recovery, through education, self-exploration, groups, and individual sessions, it's the individual's decision

Go over treatment plan with you

Ask if you are going to go to intensive outpatient after

Ask if you are going to abstain

Go over and talk about it with you

Asked what I was going to do when I got out

I was involved when we made the treatment plan

My counselor offered professional opinion and suggestions

I was always involved

They don't look through my paperwork/history and decide

Didn't think it would be worth a damn if they did not ask me

They drew conclusions based on my history but got my opinion, which was definitely helpful

Suggestions my counselor brought up

When things didn't make sense, I was vocal

I could choose to leave at any time

I was in control because I chose to be there and I stayed

I chose to decline the halfway house (no choice if mandated)

I could choose not to go to AA or NA

There's always some kind of dialogue we can have, we have conversations

They make suggestions things you need to do to motivate your goals to eliminate substances from your life

Team meetings you can make requests at the beginning and throughout the program

I wrote out my goals

Made the choice to relocate after treatment and the social worker helped with that goal
 I was all in in making decisions that's what I was there for
 I wasn't trying to fight it, I was open to whatever was necessary
 I had my own decisions to make
 The staff was in agreement with my choices because I was very involved in the learning process
 they would put it on the floor in front of me and ask me if I wanted to do this, or do that, or
 handle this situation or circumstance in this way, they would give me a choice
 I was 100% in control of that as far as making the decisions
 they included me in all the decisions that they made
 They would talk to me first about it, and then I'd give them the yay or nay, then we'd just move
 right along to the next decision
 If I disagreed they wouldn't take it harshly. They would just make a suggestion if they seen as
 though I really should go that way
 If I wasn't feeling like going that way or doing it their way, that particular way, they would just
 let it go and say, "Okay, we respect that," and just move on to the next topic
 Very much involved, I was hands-on because that's my life. It's very important for them to assist
 me, but it's really they're only assisting me. It's my life that I have to understand
 I had input on what I wanted to do
 They were willing to help me with my treatment plan and tell me, "Well, if you want to work on
 this, these are the steps that you have to take."
 When you get there you have to go through a treatment plan. They set goals, they ask you, "What
 do you want to work on?"
 they would ask us like do we want to do music therapy or do we want to talk about this topic the
 following day, and it wasn't always just, "I'm saying, well this is the curriculum and you guys
 have no say so
 part of me being engaged in my treatment, is to be able to tell my therapist here what type of
 stuff I need to work on, I feel as though that I have a voice or an opinion, and you don't have to
 always shut me out
 sometimes she helps me with my treatment, but then sometimes I tell her what I would like to do
 and she goes with it. So, I like that we have this **mutual understanding**
 The post-traumatic groups, they helped us set goals
 I was fully involved in everything, getting through the withdrawal, where I'm going to stay when
 I leave, who am I not going to talk to anymore

Once the doctors determine what kind of care and health you're in and if you need medication,
 they will bring it to your attention first and tell you exactly what they think that you need or will
 help you, and it's your decision and choice to take these meds and advice. They come and ask
 you. They don't force or make anything, so you have a big part in the medical care that you get

I wanted to be involved in any decision-making, if it was pertaining to me, and me alone. I think
 who would have a better say than me? I'm the one that's going through it. I'm the one
 experiencing what I'm experiencing. In fact, I tell them my input, and then we'll sit down, and
 they discuss what I might have put out there to them and they'll put out there with their training.
 They have degrees to give me the input and say, "Well, we think this will help." And they don't
 just force you. They explain it to you to the best of their ability, and you take it from there. And

most of the time, likely, you want that help. You got professional help coming at you, not making you, and giving you their input and stuff

Appendix K

Presence of Patient Participation

Presence of Patient/Person Participation (Process)

At the end of lectures or groups they solicit input, comments or concerns

Feedback questionnaires

Questionnaire at the end a little more in-depth for program change

Was glad they gave feedback forms

Had an opportunity for addressing concerns

People had suggestions

They were ready to listen if you had suggestions

At the end there's always an evaluation to fill out

Sometimes they call after

When I left there was a questionnaire to rate the program, what would I change, it was the most input while I was there

I made suggestions

They had a suggestion box

I gave feedback on a class and they extended it

They might stop me in the hall if I'm coming from lunch, or dinner, or something, and they would ask me, "Well, what do you think about the program?"

They asked me, "How do you see-- what kind of improvement would you make in this program?"

They asked me like a little evaluation. I would give them my own feedback on how I felt

They might get it from this or that person, or put it in a little jar but they might come out with something different

There was a suggestion box

I was asked different questions, I went, "Wait a minute, I remember I put that in the box,"

I always give them feedback I always have something to say

If I see something that I need that I'm not getting or whatever, that I think it can be implemented in the program, I will let them know

They gave a survey to find out how things were every month how everything was going on, how the program was ran

you have fill out a survey when you discharged. Some of the questions on there is, how do you think we can make this facility better? Were the people here satisfying to you

we did a survey near the end of our-- at our discharge

They asked us to form a board, we formed a board, we had a president, we had a secretary, we voted

We took surveys, "How is staff treating you?"

Questionnaires, confidential, you can sign it if you choose to, or initials, you didn't have to

They wanted to get the client's input on what could they do to make things better

Appendix L

SOC Upon Entering

SOC Upon Entering

absolutely prepared to make changes

very motivated

wanted to participate

threw myself into everything

hopeful

a high degree of hope

knew things would work out

definitely ready because my health had deteriorated over the years that I had been drinking

I was very much ready to change my life, get myself back in order, so I get my kids back

I was ready to go, I was like, "There's nothing to stop me to get my recovery." I was raring to go

I was ready

I was really open to doing anything. I wanted to learn as much as I could

Very ready extremely ready

It's a mindset

All I wanted was to do was to do good, become a better man, for myself

Being that I had relapsed, I was actually very ready to make changes

I've been in and out of treatment for a while and I had some clean time before and then I relapsed

Very ready, I read a book that inspired me to change

I became very motivated

if I did what I was told it would work

I had the tools

knew I wasn't any worse than others

I had a spiritual awakening

I was ready and willing to enter the program

I was pretty much ready to make changes

I had to change

My way was not working

If you're not ready, you're not ready

I was hopeful but pessimistic

Not 100% ready

wasn't sure what to expect

I was emotional at intake I didn't want to be away from my family

Needed change wasn't willing at that time

It was voluntary, but it was kinda forced

I was beaten down, I was ready. I was ready to do what it took

I needed it at the time, I just needed to do it

I knew deep down I wasn't done but I wanted to stay clean and sober at that time

I needed to be successful, I had no choice

I was at a point where I needed the help

I needed to be in an inpatient environment

this time around going into treatment I kind of humbled myself. And you know learned to take suggestions. And I was willing to do something different
I was still a little shook up about my relapse, and I had learned how to listen more and talk less
I thought I had all the answers but if I had relapsed and I came back, I had to listen to people I can't really put a finger on the exact emotion that I felt, or the exact day that I woke up and was like, "Oh, I want to really stay sober this time." I can't do that, but I do know there was something that, for this time, just felt different
I wasn't ready I hadn't accepted a few emotional issues I was having
It's a lot of help it's scary, and I very much didn't know what to expect
I didn't know what to expect
I'm frightened, and I know I'm coming down off of drugs and I'm trying to get my life back in order
some people aren't there for treatment, some people there just to rest, or maybe their check's going to come, but I blocked out everything and said, "You know what, I'm here for me and I'm going to keep an open mind and take some suggestions"

Appendix M

Consequences of Use

Consequences of Use

several hospitalizations
 lost jobs
 unsuccessful at outpatient
 symptoms of depression and anxiety worse with alcohol
 damage to family relationships
 could not stop on my own
 make a go or die
 tired of waking up in hospitals
 wanted the hell out of the hole
 Drinking end stage alcoholism for a number of years
 Nonfunctional
 Non-employable, couldn't hold a job, downhill from the interview
 Couldn't do anything but stay at home, drink, get drunk, pass out
 People don't get it (isolating)
 I was sick for so long
 Went to detox so many times
 So many meetings, so many people praying for me
 Used to discharge from detox and go to the pint store on my way home
 Couldn't stop
 I know very few people who suffered the physical and demoralization I did for a long time
 Hospitals, detoxes, and rehabs
 Never knew anyone with more treatment than me
 Husband had good insurance or I wouldn't have gone to treatment
 Past rehabs, 2 days later, 15 min later I was drunk
 I disappointed myself
 Didn't think I would stop or get better
 Thought I would die of the disease
 Hospitalized intensive care at least three times
 It was really bad
 There's always hope
 When other people stopped after the 2nd, 3rd, or 4th rehab I thought what's wrong with me
 7 rehabs, 50 detoxes, hundreds of meetings
 I was killing everybody
 It's a family disease and I was killing my husband and kids
 Drove my kids away and it was affecting them
 It was affecting everyone around me, everything
 I don't want to feel guilty anymore
 I don't want my kids to be ashamed of me anymore
 I don't want my husband to be mad at me anymore
 Don't want the paramedics to say Oh it's that drunk lady again
 My neighbors knew, it was bad

I knew when I said hello they thought that fucking drunk bitch loser, why can't she just...
 Nobody likes to be looked down upon – we want to be successful at everything
 I was sure as hell not successful when I was drinking
 I had people praying for me daily, I still couldn't stop
 You feel guilty when you relapse because everyone is pulling for you, husband, kids, counselor, friends
 My husband was beginning to have doubts and thinking of leaving
 It was either that [treatment] or be homeless and have nothing
 If I didn't go everyone was going to cut ties with me
 If I didn't do it I wouldn't have a place to live, family, or any support
 It was either this or go to a homeless shelter and start over with nothing
 Cocaine has a devastating effect
 Alcohol has the most devastating effect
 Incarceration
 It has a devastating effect, it always does, always does, always did
 I had a nice cushion at one time (finances)
 I didn't want for anything but I neglected myself so much
 I was unable to fulfill my obligations
 You get to the point where you just can't stop
 You think this is enjoyment, there's no enjoyment
 I had to break that chain, get the chains off me
 It takes a toll, the disease
 Using had an effect on my associations, girlfriends, separations, breakups
 My health had deteriorated to a point where I started getting seizures, and high blood pressure
 passing out when I drank too much
 drinking 35-40 years, started age 12
 At the rate that I was drinking, when I was drinking, I was overdoing it
 my health is what got me here, what made me to come in this time
 I'm too old for this, my body can't take it no more
 the hospital called me and told me that my mother was in a coma it took them three weeks to find me
 I really haven't fully grieved over losing my mother because she was everything to me
 I'm tired of waking up in hospitals or either I did something then have a complete blackout and don't remember
 there are certain individuals I can't associate with anymore, like old friends who are still active addicts
 when I had relapsed then it was really, really hard for me to get back on the bandwagon
 I was homeless at the time sleeping on the bench for like two to three months
 I was cold and wanted to be inside trying to get my life together so I could find a better way to live for myself
 I remember the times that when I picked up I would fail, I would keep going in and out of treatment, I wasn't willing to do anything different
 I blame myself for the death of my mother, I knew that kept me getting high

Appendix N

Negative Outcomes and Contributing Factors

Negative Outcomes and Contributing Factors

I've had quite a few relapses since then

I've tried to figure it out so many times in so many programs

Success (trigger) when things go well I tend to mess up – that's a big one, that's the main one

When things are going well, I think "you can do it, you're doing good"

When things are bad is not when I tend to relapse

When things are going well, that voice in my head says you deserve it [heroin]

Even though I know deep down what's going to happen I do it anyway

I have relapsed since treatment

It's not really completely over, it's a disease

A scenario comes about, next thing I know here I am back in that motion

The first time I went to treatment I felt like it was over but it wasn't

the issue with me is not just putting the alcohol down, but maintaining it

even though I have about four months going on five months clean, I'm still vulnerable to pick up to drink again

I did well for a few months and I got overwhelmed

I didn't go to outpatient, so that's what I lacked, that was one of my downfalls

I recently lost my mom so that was very detrimental to me and devastating, it's like I don't have anybody now, I'm by myself, the only way for me to be better for myself is to get myself together

I relapsed after that maybe like two years later it was an abusive relationship, she was abusing me, we was drinking every day, going out, and it wasn't no good

I never divulged certain issues to staff it was no surprise I picked up the same day I got out

I got high the first day I got home, I felt like I needed relief, I mean I was just so frustrated, and I felt let down. I felt like I got...again, nobody cared. I got high. I picked up that first day I ran back to what I knew was a comfort to me because I wasn't shown any new behaviors, so I still had those old learned behaviors that wasn't worked on at all

Like six months, and once my insurance ran out, I was wondering, "Damn, now how am I going to continue OP if I don't have no insurance?" So that's something that I just let bring me back, slowly but surely back to the wrong side

Appendix O

Positive Outcomes and Contributing Factors

Positive Outcomes and Contributing Factors

Staff believed I would come out and have a successful recovery
 Hope and confidence
 Very strong foundation to build good recovery
 They provided me with everything I needed to establish good recovery once I got home
 Gave me confidence in myself
 Gave me psychological and social tools
 Taught me everything
 Ran me through the paces
 Got me as healthy as they could
 I was prepared and educated
 I was socialized to 12-steps
 Dropped me at the starting line up to me after the gun fired
 I could get back into recovery if I had stumbles and falls
 One foot in front of the other
 Go to meetings
 Reach out when you're not well
 Do the things you have to do like therapy
 My spirituality
 My family, wife, support, those that were there for me
 Supports not being patronizing
 Believing in me
 Positive affirmation
 Spirituality and connecting to 12-Steps
 Support from people closest to me
 Didn't drink when I got out, finally stopped
 Went to meetings sometimes 2 a day
 Life is not perfect but it's better than I could have imagined
 I have hope
 For the first time ever I stayed sober
 It was different from what I expected
 I always had hope
 I expect to stay sober but there's an underlying fear
 I'm a miracle, I'm a miracle
 Nobody thought I was going to get sober it's unbelievable
 I had a spiritual awakening
 I haven't had any relapses I'm still sober today
 I'll never know the reason, how or why, I got sober this time and not the others
 I felt good, I tend to recovery quickly
 Very social, socialize when I feel better
 I always feel good
 12 steps always discussed the most successful route to take

They always talk about AA and sponsors, I like meetings
 Thought it was going to be worse than what it ended up being like
 I felt hopeful
 As you're there you get clean time
 As you get clean time, you feel better
 You just start feeling better mentally and physically
 Everything starts coming together
 The longer you're there the better you feel when you're out
 The longer you're there, the more ready you feel for when you move on
 I felt good
 I got stronger in a positive way until I left
 After the first month you're rolling downhill gaining momentum in a positive way
 By the time I was ready to go I felt really good mentally and physically
 I was ready to go
 I was really pretty confident
 You know what you need to do and you just do it
 I successfully completed
 I still think about "playing the tape through," thinking about the outcomes
 I followed up with continuing care
 After, they referred me to another program
 I was determined to stay clean and sober, so I went to aftercare
 I was told I'm still part of the process we're always here for you should you need to return
 I'm a part of the alumni
 I can still talk to someone from the program
 I knew it was going to get better once I just put that alcohol down
 Haven't picked up a drink since I've been here (almost 6 months clean, halfway house post Tx)
 I had to get a sponsor I usually attend meetings
 I was always willing to go to any length. Because see when I was using, I went to any length to get high. So, why not use that same energy to do the same things as far my recovery is concerned.
 I stayed clean for two years after that
 I got me a sponsor. I was going to meetings, and I didn't relapse when I was there
 They got me a place, I was in the assisted living, and it was good there. I had my own little apartment that was mine. I could say after I completed the program it was mine
 They give you extended amount of time to sit there and get to know yourself
 Stayed away from the chaos, confusion, and I completed
 they give you a certificate and they give you a send-off
 when I graduated I was extremely motivated about staying clean, but I had to remember that I had relapsed, if I didn't take a look at certain behaviors, I could end up back again
 I like to take it one day at a time. So I know that every day is a learning process
 I consider myself to no longer being held hostage by addiction, and I'm learning to stay clean
 Each time just gets harder. Each time it gets harder. And that gives me more motivation, not only to not return or to pick up that drug
 Because I can always think back to that drug had me, or drink had me at the lowest. I didn't know if I was going to get the help that I needed, but I did. And I'm pleased that I got the help that I needed. It showed me a whole lot of positives

they instilled in me like, "You don't have to ever come back. But if you do come back, and you're fortunate enough to make it back we're here for you, and there's nothing to be afraid of."

Appendix P

Absence of Recovery Model

Have to be motivated, committed
 I was lucky to go that program
 Was all up to me, outcome was up to me
 Beat the odds if I did what I was supposed to do when I got out
 Counselor knew it was up to me
 Didn't feel the need to go to them, no need for them to come to me
 I was different than young people
 I don't see myself as a cultural person
 Weren't very many of us middle-aged geezer alcoholics, beneficial to have similar peers
 Didn't have a lot in common with patients
 Asked if I was going to follow through
 They saw I had repeated failures and asked me how I would fix that
 Not a lot they could do for me, just hope and pray (seasoned rehabber, knew the ropes)
 Staff say you're responsible for your recovery
 The only cultural question I could think of was did I have a religious preference
 Some of it you feel like they're obligated to say (positive things)
 Can't be dirty – didn't tolerate use
 If it wasn't for him pulling some strings, they probably would have red flagged because I have
 been in and out in so many different programs through the years
 took me in and they told me if you serious enough that you will abide by the rules and
 regulations
 I did get overwhelmed and I should have used the tools that they taught me there
 Some of them just doing their job
 Sometimes they just didn't want to interact with certain people
 A couple of them tell where they came from in they life they can do it then I can do it. All I have
 to do is just put in work
 They would tell us they knew that we can do it, we just have to want it
 at the end, I wasn't using the tools that they gave me. It was my fault
 Taught me a lot of things, I was using it for those two years until I just finally decided to take my
 will back that one day
 staff might have felt worried for me a few times because one of the statements that they made to
 me when I came back is, "What am I willing to do different
 when it came to me being discharged, or working on my own recovery, they were kind of iffy at
 the time
 They were worried about my treatment at the time while I was there because they wanted to see
 if I was going to do things if they suggested for me to do
 In order to get "late night," to stay downstairs and watch TV, we would have to keep the
 lunchroom clean, throw away trash, stuff like that. Sometimes an individual would make a
 mistake and the whole community would suffer
 We would go into "room time" every day and I know they would do change of shift but a lot of
 time when we would be in room time, there wasn't really anything for us to do. The room time

wasn't necessarily-- I wouldn't say it wasn't appropriate but we just had this block where we did absolutely nothing

I relapsed, I kind of don't understand about how an individual will come in and out of a treatment facility, and they know that they have a drug and alcohol problem, but it's almost like they don't believe in you because you consistently go in and out, in and out, in and out

They were kind of judgmental at first because I've been in and out of treatment for so long

I just don't like the whole judgmental thing because somebody that consistently uses drugs and alcohol but then can find a point where they realized that they were hurting themselves and messing their life up

Being judgmental with people that are chronically relapsing, are people that have a drug and alcohol problem

When I think of the word culture, I think of my background growing up, my environment, and all that. It wasn't anything we talked about

I wanted help with housing, I was discharged to the street, I was homeless

It's hard for me to trust people and I just wasn't around them long enough to trust them-- to trust that what I would tell them, would stay within those walls

I wish they would have done more to open me up

It's not like I don't know who I am and what I feel, and what makes me feel this way and what makes me feel that way. I'm not confused and lost. I know what I need. I know what I'm going through

If I feel as if I cannot trust an individual, I'm not going to open up to them about what's going on with me

You couldn't think for yourself. It's like you were incapable of thinking for yourself

I wasn't hopeful at all. Not at all

Going into a facility where they don't ask you, or they just assume what's going on with you. It's made to where you feel like it's just useless and pointless in even expressing to them what you're going through, there's already a protocol, "Hey everybody coming here is the same, going through the same things,"

In the beginning doing the intake, they ask you who would you like involved in your progress, and they never got in touch with my wife. They never called her in for a family conference before I left so there was none. She might not have divorced me, I didn't know how to explain my addiction to her.

Techs wouldn't listen, they're supposed to be there for your needs

I had like one guy, a peer specialist, out of everybody that actually cared and took his time out to help me

If I took extra cereal he would explain to me, "That's a behavior. You're trying to be slick, and that's an addictive behavior." He'd be like, "If you don't change that up, that could lead you into potential relapse or death." this is someone that's 13 years clean, so obviously, he knows what he's doing

Appendix Q

Absence of Person-Centered Care

Absence of Person-Centered Care (Including Needs, Preferences, and SOC)

Heavily integrated 12-Steps
 Staff have been doing it awhile and it seemed to be working
 People newer need more
 Given a treatment plan
 Everyone did the same itinerary every day
 You weren't given options of what to do
 It was the same for everyone
 Wasn't too goal oriented, focused on now and why you're here
 Didn't go over too much like goals, just how to stay clean now
 Gave me lots of reading assignments, which I didn't care for, but I liked him
 Didn't have too much of an individualized recovery plan, everything done in groups
 Divided by mandated and voluntary
 All groups chosen for you and everyone went, we had to go as a group
 Things I needed to work on, not initiated by me, brought up by my counselor
 Didn't really have long-term goals
 As treatment went on, I don't remember them asking about my needs
 It's a general format they have set up [template]
 They have a layout of how they want to conduct their program [template]
 You have an intake and they present goals to you in the beginning
 they pretty much had their own criteria as far as groups [template]
 The organization itself had it set up way before I even there [template]
 They didn't ask me my preference on anything, not that I can remember
 they already had a program already mapped out there [template]
 Everybody goes to the same class everyday it was mandatory
 Sometimes the overnight staff. You might wake up 1:30 in the morning. You might want to talk
 to them. They might not want to talk to you sometimes I felt bad about that
 You had to go to the same groups. It was mandatory
 when you go into the program, you have to be willing to do things that you don't want to do
 we had a curfew some nights it was all about who was working and what was going on
 After you was there for a while, they allowed you to get a pass and go to church
 I don't think they asked me if I had any support system set in place
 I don't remember even working on any of my goals in there It was just more or less the line of
 talking, opposed to putting the talking to action in some type of form
 It was a laid out thing for everybody [template]
 You were expected to go or they could discharge you, if you didn't participate in the groups
 They never took in consideration, it's not like they would ask you, do you think this would be
 beneficial to you
 They look at everybody the same, to me everybody is not the same
 you didn't have a choice, it was already laid out, it was tailored to what they thought I needed
 how can one do that if you don't have a say in your treatment or even be able to suggest, "Well,
 this is what I need

I didn't see her every day. So yeah, that was a problem. I felt if I probably could've seen her more, I could've gotten a lot of stuff off my chest
they weren't genuine and helping with my needs
It was the same thing every week
I felt like I was always the one saying, "Can you do this? Can you do this?" Or me even doing it because they wouldn't get done when I needed to
They told me that they would take care of it, and they never did
You have to put the leg-work in
I did try to ask if there was any kind of Jewish thing I could go to because they only had either church or Talim, I'm not Muslim, they said you have to pick one because they locked the unit. I ended up going to Christian church every time.
These groups were already set in motion, so when I went, they were already there, for years
[template]
They had a pre-set schedule already [template]

Appendix R

Absence of Shared Decision-Making

Absence of Shared Decision-Making

I left it up to them
 I couldn't stop on my own
 You're not the captain of the ship
 Have to follow
 Your opinion might not be the best right now
 You're still detoxing and might not understand what's happening
 Put faith and trust in other people that know what they're doing
 Staff could see where I needed work, if counselor didn't see a need, or you didn't ask, you wouldn't get it
 We were shown our treatment plan
 Demonstrating I was following through integrating what they were teaching
 Did what I was told through treatment
 Not much choices besides what to eat, wear, read, or watch on TV
 I really didn't want to have to make any decisions – I knew I didn't have a choice in much anyway
 I was going to let them do whatever I had to just to get through it
 They know better anyway – doing it my way was no good
 I didn't want to be too involved in decisions about care
 I don't know what I'm doing it's my first time there and that's the way they do it
 I'd rather have them do it - they know better than me
 I really didn't want to have to make any decisions
 Sometimes, I wasn't pleased with the recovery coach's decisions – she meant well but I didn't always see eye to eye
 They would tell you when you are there what classes that you need to fulfill
 we had to go to meetings
 Sometimes I felt like when I was in rehab that they might have thought that because I was there to get help, I kind of necessarily didn't have no type of feedback
 it was kind of like “**you can't tell help how to help you**” thing
 at first I didn't really have a say so, but as I went through DBT and talked to the psychologist and my therapist, I helped go through my process
 I'd relapsed and I came in and it's like “**you can't tell help how to help you,**” sit down, not really say a lot but let us guide you through this process
 They made most of the decisions. That's what it felt like to me because even though I was telling them that I needed more time in the program, they were telling me that it was impossible, they lied to me
 They put me on medicine for everything
 They tell you who your therapist is going to be. It's really up to the therapists, they run the groups
 I wanted to be fully involved because I know nothing would have been done
 I learned my lesson a long time ago. I know you got to do your own work

the first time I went in they said, "Don't worry about it. We'll get you in somewhere," and when my days came to an end, they threw me out to the street, and I ended up using again.

Appendix S

Absence of Patient Participation

Absence of/Limited Patient/Person Participation

Feedback opportunities were limited

Informal

Plug and chug numbers

Questionable if anyone did anything with it or read comments at the end

Don't know if it was incorporated

Informal with staff you interacted with

Majority was informal and could not be tracked

Not done through consistent way

I wasn't interested in changing much

The place knew what it was doing

Wasn't a need for it

Tenets follow good orderly direction, that's why I didn't feel the need to change anything about the program

Not going to criticize the program

They need your feedback to be successful, people hear which programs are good and which are not

I liked the program the way it was

Not a lot you can do about how it's decorated or the food

I'm there to get sober

A junky place works just as well as a nice place

Plenty of people get sober there

Place was nice, kinda junky

Wasn't the nicest, wasn't the worst

The surroundings do factor in

I would have liked it if they had asked for my feedback on a weekly basis or had a suggestion box, or weekly groups for feedback or to share ideas

To me it was just a job, so it wouldn't even matter [my feedback], had it not appeared that way, I would have wanted to be involved

They would get us all together every now and again and be like, "What can we do to help you guys?" Just get our feedback. It happened two times while I was there in five months

I believe there was a suggestion box and a grievance box I heard a lot of complaints about, "I put this in forever ago and haven't heard anything."

The top lady would come and say, "I'm going to do this, this, and this to help you guys," and then ask our feedback, and we tell her, and then she would never do it. Things just didn't seem to get done

I would have liked respect, them reading the suggestion boxes and the grievances, looking into the grievances and actually doing something about it. We didn't have a water thing, it was broken for a long time. I don't know if that really counts, but we kept trying to get the water thing fixed. It was really, really hot. We had no air, we were all literally sweating to death in there. They wouldn't get anything done about that, it never happened

Appendix T

Organizational Stress and Trauma

Organizational Stress (including all components)

lucky to have a skilled counselor
 lucky to have best counselor on unit
 different quality of counselors
 some counselors not liked
 some counselors come down hard on people
 opinion that addicts deserve what they get
 very punishing point of view
 wasn't trying to see problem from patient's point of view
 felt condescending and forever colored my opinion of him
 wasn't interested in his feedback
 thankful it was the only interaction
 didn't let it get me down
 didn't take it personally
 if I felt criticism I sought encouragement and support from staff and patients
 good counselors smell bullshit
 thought I was too good to be true
 thought I was there to pull the wool over
 wary of people who are motivated
 afterwards was able to see I was genuine
 staff realistic not fatalistic
 a lot of addictions counselors, and I don't want to say are jaded, but are just used to the
 overwhelming majority of people in treatment are gonna relapse
 I remember that statistic of 1 in 10 is gonna make it, that's what they were saying at the time
 we'd all look around and count, you know of through the community
 if you believe statistics um, 10%, 90% are gonna go back out maybe not even get back into
 recovery
 Staff said I hope it works this time, I hope she frickin gets it this time
 Some staff were hard on people
 They'd say it's time to straighten up and stop breaking the rules
 Had to be more stern or terse with those people
 The staff knew I had been around
 There were worse counselors, I was lucky to have mine
 Two counselors I didn't care for, unprofessional
 Staff is pretty pessimistic not because of you, but what they see
 When someone completes treatment staff are pleasantly surprised
 If he would have went to work one day, and I wouldn't have been there, I don't think he would
 have been too surprised because that's what they see
 They would say in some groups, "Look to your left and look to your right, and remember the
 faces of the people you're sitting next to because one person that you just looked at won't be alive
 in the next five years."

If the statistics show that 50% of these people aren't going to make it, how surprised can you really be when someone doesn't?

It's more or less what you put into it

I had certain dislikes of individuals the way they came across

some of them shared stories with me as far as individuals thinking that they're ready when they're not really ready - when they would mention that to me, I would just tell them that, "Look, I've been there and done it, and my health right now is the reason why I'm sitting here talking to you

Well, it's good that they do bring that up about clients leaving just to see where the individual that they're talking to is really serious about it or not, because a lot of jokers here aren't serious

I'm just here--I can only take care of me, worry about my own recovery

it just lets me know that I'm in the right place. The ones that have fallen off, all I can do is keep them in prayer

they seemed stressed if they were trying to get a client into a program, they didn't give up those times that I've seen where staff was stressed at that program if a failed attempt to get a client into a particular program

you could tell that something's going on with them. So you just pretty much keep it moving and just let them calm down

a few times, the staff came back to me, pulled me to the side, and said, I apologize

they would apologize, and I appreciate that

because a few programs I've been to in the past where the staff was just completely nasty to the clients, disrespectful. And I don't even understand how they became staff really

they talk about that [negative outcomes] a lot because we have to understand that it's a disease that we're dealing with. They try to let us understand what's really going on. I don't want to go back out there and be a statistic

Keeps me on my toes. The bad stories keeps me green. It keeps me understanding like the disease is going to always be out there

I was willing to go the extra mile, and once they see that they're much more prone to help you more, I think

Arguments every now and then. It was really minor. I've witnessed that one time

There were two of the staff members, they were arguing over a client

I'm sitting there going, "Why would they start arguing like that. For what reason?" And it wasn't professional, later on, they apologized to each other, though. It wasn't later on that day, but it was later on in that week that I've seen them apologize, even give each other a hug

When the state was coming, that's when they like, "Well don't bother us now. We got to do this."

It's like, "Boy, you still have to run a program." You're worried about the funding now, but the program still goes on. What about us?

A couple people died while I was there. And they felt bad about it. They were sad

they wouldn't like it that the person left. They would be upset

I could say that some days staff there might have had their own personal problems

Had a lot of people within that building, so they couldn't always take care of everybody's problem individually

Because it's a lot of people at that place at the time it might be hard to individualize and help people, like, an individual basis

Before the meeting would start the staff would always make this statement, like you know the statistics, not all of you guys are going to make it

As a recovering addict hearing that statement, "Not everyone's going to make it," it bothered me a little bit that someone in the professional field was saying not everyone in this room is going to make it, but I had to kind of personalize and say, "just because they didn't think I was going to make it, do I believe I'm going to make it?"

It did kind of made me feel uncomfortable at the time when we would hear about statistics and only some of y'all are going to make it and not everyone's going to make it, and it did bother me a little bit about how they say if you keep doing the same thing over and over again, you're going to end up in places like another rehab or something like that

Staff worried in a sense like, "Are you willing to do this?" and "If you're not willing to do that, do you know the outcome of it?" I think they were invested and worried at my treatment

Some staff weren't respectful. I remember an incident with a nurse, I was really sick, and she downplayed what I was going through. Then I wound up in the hospital. When I came back she tried to be nicer to me but by then, the wound had already been opened I had saw how her true personality was at that point

they're all jaded

it almost makes you feel like the odds are stacked against you when it comes to you being successful

You feel like why should I even try when the percentages say that I'm not going to make it, or I don't have the chance to succeed anyway? What was all this for? You can look at it like that, or you can be optimistic and say I want to be one that does make it and is one of the successes in treatment

Staff's hands were tied for changing the program, but if you're not part of the solution, you're part of the problem

I can detect, and I can tell-- if I feel like I'm being discriminated against-- and it's not just a feeling, because I've been through that through my life growing up, so I see it when it's there, I tried to bring it up to them, they just blew me off. That just made me leave with bitterness. All right, well they don't care. So, why should I care

"Well, you know statistically, only 3 of you going to make it out of 15 of you." I was like, in my mind, I'm like, "Screw statistics. Statistics have been shown to be wrong too." I'm like, "Why do you always use the statistics thing?" "Oh well, because that's what they've been using forever," but statistics aren't always right. Most times statistics are wrong.

You got people on the floor looking at each other, and getting a little angry because they going to feel like they're going to make it, and you tell them statistically that only 3 out of 15 are going to make it. What kind of crap is that? That's messed up it's not a motivating thing. It doesn't

motivate you. It does the opposite. But yet, they still practice that. It's not a motivating factor at all.

One staff member didn't believe in statistics, but she couldn't voice that or she probably would've lost her job. She went against the grain

She did what she could do when away from other staff, try to help you. You know, giving you advice other than what they tell you

I know she was very frustrated with working there, because she felt like she really couldn't help people. It was like she had her hands tied. She genuinely cared.

I could see the frustration in her expression when she would, you know, speak about not being able to do this or that at the facility. It would show

they might say something like, "Oh, well, you know what? If you don't follow the process this way, you're not going to make it." And then you come back at them with, "Well, how do you know I'm not going to make it? Do you know me?" And then that's where they come with the, "Well, statistics show--" That affected me negatively. It really did. In my mind, it affected me negatively. And it had me not knowing, you know? For a moment, it did.

To me, it was nothing positive. That's not something positive to say. Somebody's trying to get their life together, that you might die. Not that they point you out or single you out, but in a way they called you to single yourself out mentally

If it wasn't for the fact they she really wanted to help people, she would have quit that job and went somewhere else

It was just a job to them really. Yeah, just a job. I mean, to me, there was no passion, they had no passion

They were pretty disrespectful [paraprofessional staff], there was a little bit of racism going on in there

I would just get ignored or just dirty looks or, "I'll do it when I feel like it."

There was a lot of disrespect. And the food line, they would just sit there and blatantly talk, "I hate these junkie crackhead people."

"They don't pay me enough for this shit." Throw the trays up at you literally

Just the way they talk to you. They're just very, very ignorant.

I had that one guy, he was nice. Other than that, they were just ignorant. I just tried to stay out of their way. They would sit behind their desk, and just sit on their phones, and just listen to music, and they didn't care.

I sense some racism, smart, dirty remarks, just very ignorant

It makes you feel like there's no point to even ask this guy for anything or talk to him or anything. He'd sit there and make bets on who was coming back and stuff like that. They didn't care, at all

He'd be like, "Look at the person next to you." And then we'd look at each other and he'd be like, "That person might not be alive within the upcoming months." He said, "One out of every three of you is going to make it. That's the statistics,"

It's mainly the staff that was just real ignorant, like the kitchen staff

Sometimes I might feel the same way like the staff's saying, "Oh, she's just the B word. Always has an attitude." I was like, "Yeah, I feel that way, too."

Like, "Ah, I've been working double, triple shifts. How do you think I feel?" They would act like they were stressed over things all the time

My one therapist, he'd be trying to get things together and be rushing around. Sometimes I'd have to be like, "You need a hand in this and that?" Just maybe a little under pressure, maybe they didn't get enough sleep or something like that.

Sitting there with this look like, "Ah, these junkies." I've heard talk about the people that are in there trying to help themselves

Appendix U

Model Conceptualization

Conceptualization of User Involvement Models and Processes

